HOSPITAL
Topics
THE NEWS MAGAZINE FOR HOSPITALS

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ABBIE E. DUNKS

Program for the Second National Conference of the Association of Operating Room Nurses
. . . opposite page 42

NOVEMBER | 1954

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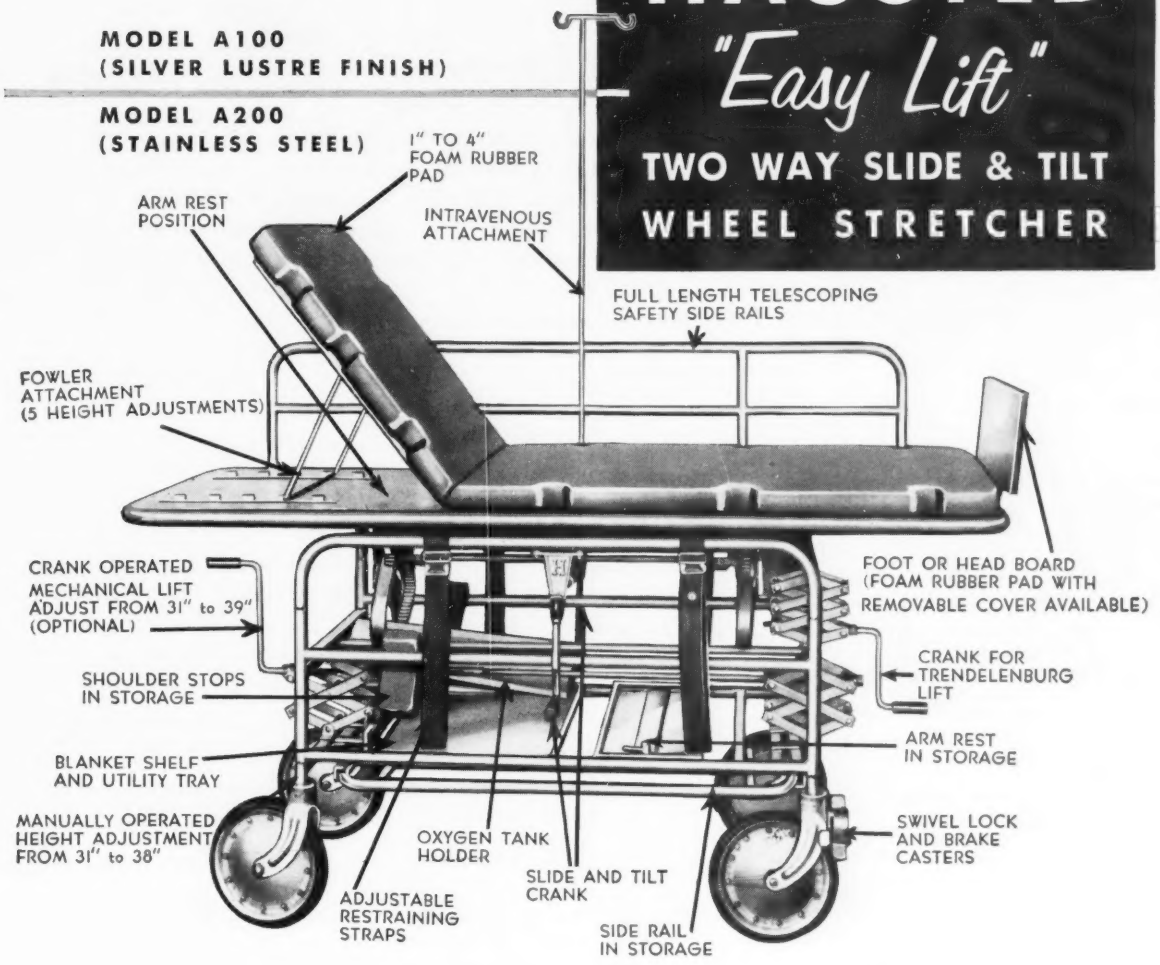
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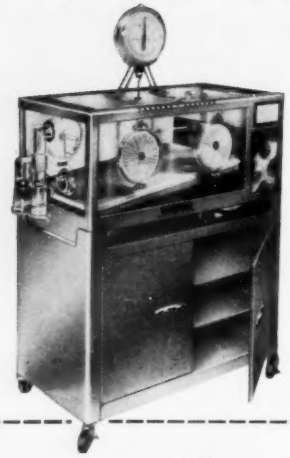

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HOSPITAL Topics

The News Magazine for the Hospital Staff

NOVEMBER, 1954, Vol. 32, No. 11

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G. M. Marshall
Publisher

J. F. Fleming, M.D.
Medical Editor

Marie Jett
Editor

Betty Aulenbach
Managing Editor

Esther Driscoll
Associate Editor

Marcella Skandis
Advertising Production Manager

Gunhild Moberg
Business Manager

Published by THE HOSPITAL BUYER CO., Inc., 30 West Washington St., Chicago 2, Ill. Telephone: DEarborn 2-5148. Subscription rates: one year, $2.50; three years, $6.00; single copy, 35 cents. Canadian and foreign subscriptions: one year, $3.50; three years, $8.00; single copy, 50 cents.

A monthly publication. Entered as second class matter at the Post Office, Chicago, Illinois.

PERSONALITY OF THE MONTH

● Miss Abbie E. Dunks, our Personality of the Month, has been director of the Boston Dispensary since 1950. Prior to that she had been assistant director of both the Boston Dispensary and the New England Medical Center since 1931.

Born in Fall River, Mass., Miss Dunks obtained her B.S. degree from Simmons College, Boston. Her first job as statistical worker in an investment house seemed far removed from the field in which she later made her career. Meanwhile, however, she was assisting in the preparation of a book on immigrant health, and it was this work that led to her first position at the dispensary in 1920, when she became office manager there.

Since that time Miss Dunks has given unflaggingly of her time and talents to hospital and health association work. At present she is president of the Massachusetts Hospital Association; member of the governing board, Hospital Council of Metropolitan Boston; member of the Governor's Advisory Committee on Hospital Costs and Finances; and member of the board of directors, Massachusetts Central Health Council, as well as other hospital and community activities.

Miss Dunks believes that the greatest problem which hospitals face today is one of education of trustees as to their responsibilities, and of the public generally regarding the full cost of hospital service and care. Only in this way, she feels, can hospitals secure sympathetic legislation regarding reimbursement for public assistance cases, and the acceptance of adequate hospital insurance premiums for the full care of those able to pay their own way.

prescription pad

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New Antipruritic Lotion

Eurax Lotion 10%, a new form of the widely prescribed antipruritic agent Eurax Cream, is now being introduced by Geigy Pharmaceuticals.

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clinical notes

Amebiasis Therapy

Dwork, in the *American Journal of Gastroenterology, August, 1954*, discusses the drug treatment of amebiasis. The following are the types of medication employed: antibiotics, iodohydroxyquinolines, arsenicals, Bismuth-arsenic combinations, 4-aminoquinoline, and emetine.

The effectiveness of antibiotics cannot be denied, but their limitations are equally apparent to the critical observer. For example, most physicians have observed side effects which are sometimes severe and surprisingly persistent following discontinuance of the drug.

The initial enthusiasm following the results of short term study of these drugs was somewhat tempered as recurrences were detected among the patients followed for four or more months. With any drug used in treating amebiasis, a relapse rate of 10 or 20 per cent is usually found when cases are followed adequately.

The latest antiamebic product of the mold is fumagillin, which is amebicidal in vitro in extremely high dilution. It produces undesirable, although not serious, side effects, and the rate of cure is high, but not total.

Out of 152 adult patients treated with diodoquin, an iodohydroxyquinoline, 16 (11 percent) showed positive stools at some time after treatment. Six of these 16 cases, however, had inadequate doses of the drug. The cure rate was, therefore, over 90 percent in adults. Similar results were obtained with 57 children. The author's impression is that this is the most dependable of the quinoline compounds.

The choice in any given case should be dictated by such considerations as previous failure of a given amebicide, history of sensitivity, severity of symptoms, presence of hepatitis, necessity for rapidity of treatment, certainty of diagnosis, and the financial status of the patient.

In choosing a drug one should not prescribe any of the "mycin" antibiotics for the patient who has a history of nausea, vomiting, diarrhea, abdominal pain, or anal pruritus following his previous use of that drug. For general use, diodoquin is a good amebicide, and does not usually cause side effects. Milibis is a satisfactory general amebicide although the failure rate in children seems to be high. Treatment with vioform results in a higher incidence of gastrointestinal symptoms.

Fumagillin is a potent amebicide and its exact place in the scheme of treatment must await continued evaluation. Aureomycin and terramycin are effective amebicides but their use is attended with a high incidence of undesirable side effects.

For amebic hepatitis, chloroquin is employed. One of the standard drugs efficient against intestinal amebiasis should always be given concurrently or after completion of the course of chloroquin.

Vitamin C in Acne

Morris, in *Archives of Dermatology and Syphilology, Sept., 1954*, describes treatment of 53 acne patients with vitamin C and citrus juices.

Of the 53 patients, 43 showed improvement. The author concludes that the study seems to substantiate the findings of the British Medical Research Council. According to the council, vitamin C and citrus juices play an important part in certain cases of acne.

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HOSPITAL Topics
The News Magazine for the Hospital Staff

VOL. 32 NO. 11
NOVEMBER, 1954

Scanning the News

Enzyme Offers New Clue To Rheumatic Fever

An enzyme product of the particular strains of streptococci associated with the infections that precede rheumatic fever may be the cause of that disease.

This finding was presented at the recent second World Congress of Cardiology by Aaron Kellner, M.D., who with Theodore Robertson, M.D., conducted animal research with the enzyme at the New York Hospital-Cornell Medical Center.

The enzyme, originally isolated in 1950 by S. D. Elliott, M.D., then of Rockefeller Institute, New York, has been shown to affect some essential metabolic system within the heart muscle when injected into animals. It also causes striking tissue damage and inflammation of muscles and valves similar to that of rheumatic fever, the doctors found.

Because other experiments have shown that some antibodies result from strep infections, future experiments will be directed toward developing an anti-toxin applicable to humans.

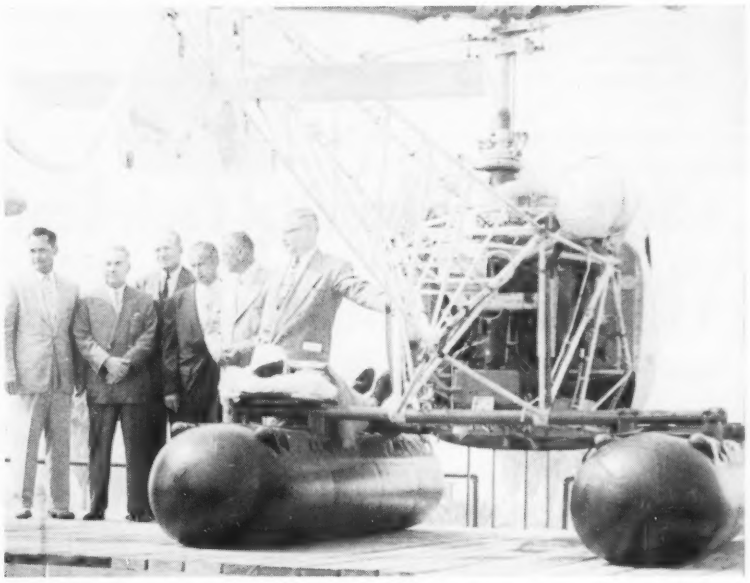
New Method Makes Skin Grafts Stick

Successful transplanting of skin from one laboratory animal to another and making it stick—a long sought goal because of its implications for human beings—was recently reported by Melvin E. Levinson, M.D., and Heinrich Necheles, M.D., Medical Research Institute, Michael Reese Hospital, Chicago. Heretofore such grafts have dropped off after a few weeks.

Key to the accomplishment, the doctors said, was the use of nitrogen mustard in animals receiving the graft. This drug, used in the treatment of leukemia, is believed to retard the formation of certain antibodies, found in the white blood cells, which resist the graft, causing it to fall off.

On rats given nitrogen mustard on the day of surgery, and for a 43-day period following, some of the grafts were so normal in appearance that at the end of 115 days they were difficult to detect. Rats not receiving the drug shed the transplanted skin in an average of eight days.

The discovery is foreseen as the possible first step toward transplantation of organs such as lungs, kidneys, and perhaps even hearts in human beings.



Test landings on the roof of Santa Monica (Calif.) Hospital inaugurated establishment of a hospital heliport there. The helicopters have been made available for rapid transport of patients to the hospital from remote areas, traffic jammed highways, and accidents at sea. Standing beside one of the airborne ambulances during dedication ceremonies are (l. to r.): A. Furlong, Douglas Aircraft Co. pilot; Lawrence Bell, president Bell Aircraft Co.; C. A. Linquist, M.D., chief of emergency service; Ysidro Reyes, head, California Ambulance Service; Ralph J. Hromadka, superintendent, Santa Monica Hospital; and Ritz E. Heerman, past president, American Hospital Association.

Scientists Isolate Potent Growth-Promoting Agent

A highly purified form of the potent growth-promoting material long known to be present in the tissues of rapidly growing embryos was recently announced by the University of California.

The substance was extracted from chick embryos by two of the university's scientists, Drs. R. J. Kutsky and Morgan Harris. The new method of isolation, developed by Dr. Kutsky, also enabled its identification as a nucleoprotein.

Applications predicted for the new factor include the speeding of the growth of new tissue in the treatment of severe burns, and the mass laboratory production of living tissues for medical use. It is also considered possible that the new agent may help laboratory workers grow complete animal or human organs in a test tube.

Foot Pills Go To Their Heads

Two formerly bald Scotsmen can thank their aching feet for their present heads of thick hair. The hair raising occurred when the two men took pills, prescribed by John Kelvin, M.D., of Glasgow, to ease painful foot cramps.

Reporting on the phenomenon in the *British Medical Journal*, the doctor said each man took one pill four times daily. Two hundred and fifty pills later the hair appeared.

Whether the patients' foot pains were relieved was not mentioned.

Calendar of Meetings

NOVEMBER

1- 5 Institute on Nursing Service Administration, Vancouver

1- 5 Institute on Personnel Administration Hotel Statler, New York City

1- 5 Ninth Southern ACHA Institute Richmond, Va.

4- 5 Oklahoma Hospital Association Shirvin Hotel, Oklahoma City

10 Connecticut Hospital Association Southern New England Telephone Co. Auditorium, New Haven

11-12 Kansas Hospital Association Baker Hotel, Hutchinson

14-16 Michigan Hospital Association Sheraton Cadillac Hotel, Detroit

15-16 Maryland-District of Columbia-Delaware Hospital Association, Hotel Shoreham, Washington, D. C.

15-17 Arizona Hospital Association Hotel Westward Ho, Phoenix

15-19 American College of Surgeons Atlantic City

17-19 Florida Hospital Association Colonnades Hotel, Palm Beach Shores

29-Dec. 1 American Association of Military Surgeons, Hotel Statler, Washington, D. C.

29-Dec. 2 AMA Clinical Session, Miami, Fla.

29-Dec. 3 Institute on Medical Records Hotel Statler, Los Angeles

DECEMBER

1- 3 Institute for Operating Room Supervisors, Blackstone Hotel, Omaha, Neb.

2- 3 Illinois Hospital Association Hotel Abraham Lincoln, Springfield

2- 3 Missouri Hospital Association Hotel Jefferson, St. Louis

10-11 Virginia Hospital Association Hotel Roanoke, Roanoke

13-17 World Congress on Cardiology Scientific Sessions of the American Heart Association, National Guard Armory, Washington, D. C.

13-17 Institute on Hospital Law, Knickerbocker Hotel, Chicago

13-17 Sixth American Congress on Obstetrics and Gynecology, Palmer House, Chicago

1955

JANUARY

24-27 Second National Conference for the Assn. of Operating Room Nurses, Hotel Jefferson, St. Louis

FEBRUARY

4- 5 Midyear AHA Conference Palmer House, Chicago

9-10 National Association of Methodist Hospitals and Homes Palmer House, Chicago

9-11 American Protestant Hospital Association, Palmer House, Chicago

MARCH

7-10 Ohio Hospital Association Netherland Plaza Hotel, Cincinnati

17 Wisconsin State Hospital Association Milwaukee

28-30 New England Hospital Assembly Hotel Statler, Boston

APRIL

20-22 Southeastern Hospital Conference Atlanta Biltmore Hotel, Atlanta

21-22 Carolinas-Virginias Hospital Conference, Hotel Roanoke, Roanoke, Va.

25-28 Association of Western Hospitals Civic Auditorium, San Francisco

27-29 Mid-West Hospital Association Hotel President, Kansas City

MAY

2- 5 Tri-State Hospital Assembly Palmer House, Chicago

11-13 Upper Midwest Hospital Conference Hotel Nicollet, Minneapolis

25 Massachusetts Hospital Association Hotel Statler, Boston

25-27 Middle Atlantic Hospital Assembly Convention Hall, Atlantic City

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News Briefs at Press Time

HOSPITALS HAVE ACCREDITATION BLUES

Is the Joint Commission clamping down too hard and fast, lopping hospitals off accredited list before Commission's manual is available as a guide in planning their programs?

That's what some administrators in Midwest are asking, following loss of accreditation by three well-known hospitals in one city.

Medical staff organization and attendance at medical staff meetings seem to be big pitfalls. One administrator told of a small hospital, topnotch in most respects, which failed to be accredited because the inspector asked to see 1953 staff meeting attendance records — and they weren't good. He made no allowance for improved attendance in recent months.

Hospitals are sold on the accreditation program — but they want the rules down in black and white.

ALL PURVEYORS OF HEALTH INSURANCE SEEK GOVERNMENT EMPLOYEE COVERAGE

Insurance companies, Blue Cross and Blue Shield, and organizations like HIP of New York and Kaiser's Permanente all are bidding for contracts to provide health insurance coverage for two and a half million government employees. October 15 was the deadline for submission to Civil Service Commission of information on benefits and costs. Commission will look over information and pass it on to groups representing federal employees and government agencies. Objective is to draft a bill to be introduced in Congress soon after it convenes in January.

UNION HEALTH PLANS SHOW RAPID RISE

The almost phenomenal increase in union health plans is one of the most significant findings contained in a new government report on coverage under independent health plans. In the last five years, union plans have risen from 18, with less than 500,000 enrollment, to 76, with a membership of 2,800,000. Nine million persons were covered by independent plans, according to preliminary report, based on survey of 299 independent plans by Social Security Administration's division of research and statistics.

Besides the rise in union-sponsored plans, other changes indicated by report findings include increasing coverage of dependents and retired workers and greater emphasis upon preventive medicine (increase in outpatient services).

MILITARY AND OTHER FEDERAL HOSPITALS FIGHT REMOVAL OF THEIR INTERNSHIPS

Military and other federal hospitals will resist any attempt to eliminate their intern training programs to help relieve shortages in non-federal institutions. They made that clear at meeting in Chicago of AMA's Ad Hoc Committee on Internships. These hospitals had 521 interns in January, 1954 — about six percent of the national total.

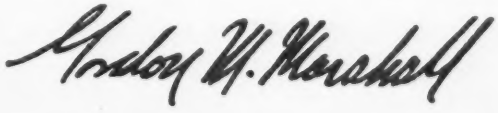
Army, Navy, and USPHS hospitals have close to 100 percent of their quotas filled, but only half of the 100 internship billets in 10 VA hospitals are filled this year.

MEDICAL TASK FORCE WINDS UP DUTIES

The Hoover Commission's medical task force meets November 5-6, perhaps for the last time, to consider report of health insurance committee and discuss findings of group that surveyed federal hospitals in five areas of U.S. Directing the windup of task force activities is new chairman Theodore G. Klumpp, M.D., president of Winthrop-Stearns, named to succeed the late Chauncey McCormick. Vice-chairman Edwin Crosby's tenure as acting chairman (reported in last month's TOPICS), was a brief one.

NEW PORTABLE RESUSCITATOR DEVELOPED

A portable anesthetic machine and resuscitator, weighing about 17 ounces, has been developed by Cleveland physicians. Robert A. Hingson, M.D., says it probably can be used by dentists to replace local anesthetic in about 80 percent of dental anesthesias — and should also be valuable in hospital emergency rooms, when short-time anesthetic is needed, and perhaps in delivery rooms when delivery is more sudden than expected.



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1st U.S. Meeting

International Congress of Clinical Pathology

S. C. Dyke, M.D., of Great Britain, retiring president, addresses the delegates at the opening session.

● *Pathologists from 32 countries met recently in Washington, D.C., for the first International Congress of Clinical Pathology held in the United States. The congress was sponsored by the International Society of Clinical Pathology, on the invitation of the American Society of Clinical Pathologists. Abstracts of a few of the many outstanding papers are published here in HOSPITAL TOPICS' report.*

Laboratories Should Adopt Assembly Line Technics

Shields Warren, M.D., Professor of Pathology, Harvard Medical School, Boston—Directors of laboratories should adopt industry's assembly line technics, and utilize less highly trained people for the bulk of the work, with a few highly trained pathologists to supervise.

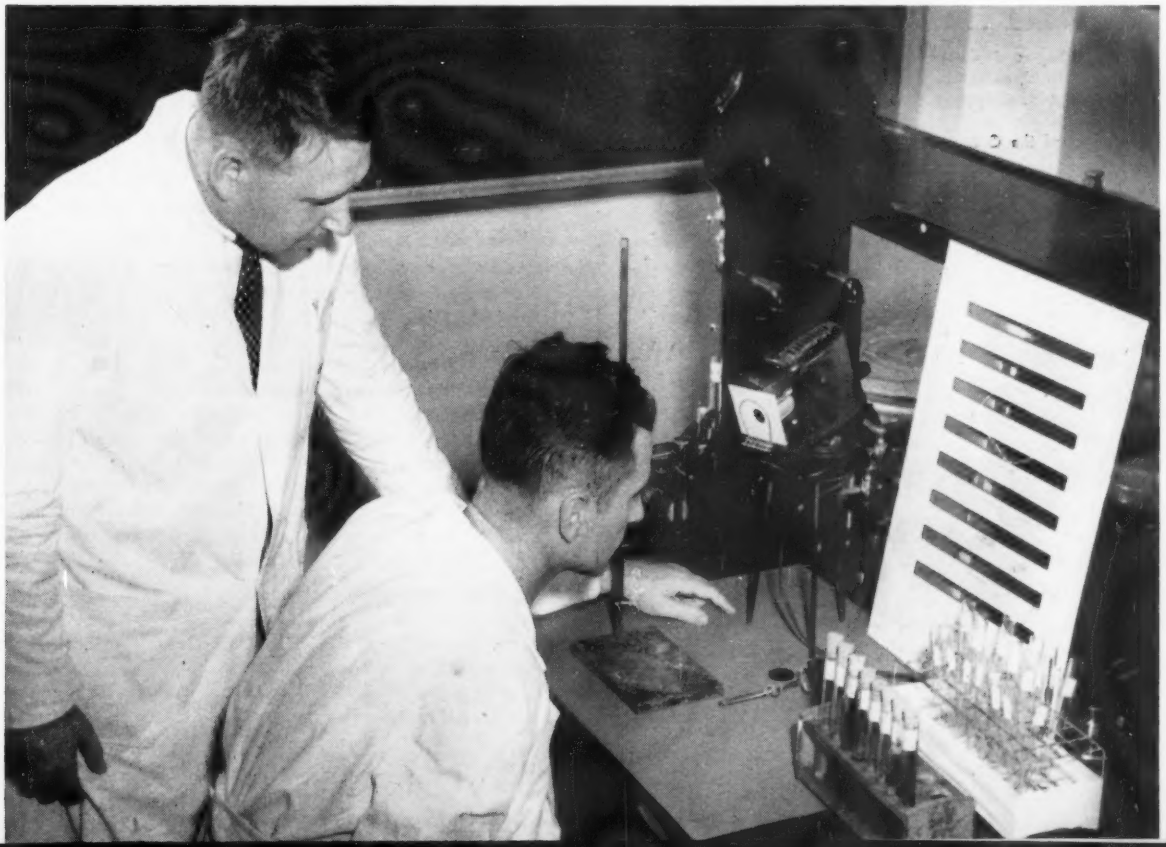
Pathologic laboratories often are overloaded by many tests which do not contribute to patient care and merely place an economic burden on the community. They should make greater use of modern scientific apparatus, such as the spectrophotometer, which in a few minutes can tell a trained technician things that previously required hours of analysis.

Long overdue is equipment like the new electronics blood cell counting device, which could have been produced many years earlier if there had been adequate communication among medical and industrial scientists.

In case of disaster, the pathologist is the man on whose shoulders would fall most of the guidance of emergency medical procedures. For the most part, he would have to determine whether patients should have blood, what type

(Continued on next page)

B. E. Copeland, M.D., and J. A. Turner, M.D., detect abnormal hemoglobin pigments with the aid of the hand spectroscope during a clinical workshop held by the American Society of Clinical Pathologists in Bethesda, Md. Official U. S. Navy photo.



John R. Schenken, M.D., president of the International Congress, with Dr. and Mrs. R. Jaffee of Caracas, Venezuela. Dr. Jaffee is an officer of the International Society of Geographical Pathology.

W. A. Douglas Anderson, M.D. professor of pathology, Miami Medical School, shakes hands with David A. Wood, M.D., director of pathology, University of California, San Francisco, and president, College of American Pathologists. Dr. Anderson was chosen president-elect of the College of American Pathologists.

John R. Schenken, M.D., outgoing president of the American Society of Clinical Pathologists, Emma Moss, M.D., New Orleans, first woman to be voted president-elect of the society, and Frank B. Queen, M.D., Portland, Ore., the new president.

they should be given, and whether an infection was present for which antibiotics should be prescribed.

Suffocation Not Frequent Cause Of Sudden Death in Infants

Lester Adelson, M.D., and Eleanor Roberts Kinney, M.D., Western Reserve University School of Medicine, Cleveland—Suffocation from bed clothes is not a frequent cause of sudden death in infants, we have concluded on the basis of a survey of 130 cases of sudden unexpected natural death in babies between the ages of 10 days and two years.

Parents and the general public should be given this information if the idea that these deaths are accidental is to be dispelled.

We concluded that the problem of such deaths is still unsolved, and that they may result from a variety of diseases whose presence had not been suspected.

Ninety-three of the children studied had died of diseases either limited to the respiratory tract or suspected of having been respiratory in origin. Thirteen died of a combination of respiratory tract diseases, plus non-related but significant diseases in other parts of the body.

The single most common finding during autopsy was acute hemorrhagic pulmonary edema. The position in which the child was found dead had no connection with the cause of death.

Miscarriages May Result from Blood Group Incompatibility

Crichton McNeil, M.D., Cyril D. Fullmer, M.D., and Elmer F. Trentelman, M.D., Holy Cross Hospital Research Foundation, Salt Lake City—We have found some confirmation for the long-standing belief that miscarriages may result from blood group incompatibility.

In a two-year study of 404 married couples, 85 couples had a history of two or more miscarriages within the first 20 weeks of pregnancy. The percentage of miscarriages doubles or triples when the father's blood type is A or B and the mother's is O. In our survey, a couple was considered to have blood group compatibility if tests showed that the father could be used as a blood donor for his wife. Couples with type O blood stand the best chance of having no miscarriages.

We noted the possible existence of a protective protein fraction in the mother's blood which may guard the unborn child from damage because of blood group incompatibility. We based this theory on the fact that babies healthy at birth may develop hemolysis a few days after birth, when the protective factor may cease to operate.

Liver Cancer Increase Observed Since Repeal of Prohibition

Hugh A. Edmondson, M.D., Los Angeles—There is strong evidence that cancer of the liver has been on the increase since the repeal of prohibition.

Cancer of the liver showed a tenfold increase in the period to date following repeal—twice that of cirrhosis of the liver—in data compiled from the autopsy reports of the Los Angeles County Hospital.

White and Mongolian groups had a higher frequency of cirrhosis than Mexicans and Negroes, but Negro males who contracted cirrhosis had a much greater tendency to develop cancer as a consequence.

Regular Exercise Helps Avoid Coronary Heart Disease

Percy Stocks, Colwyn Bay, North Wales—Physical activity continued into middle age tends to protect the individual against acute coronary disease, various studies indicate.

Even an exercise as mild as walking, if regularly en-

gaged in, could help prevent or postpone a fatal heart attack. Evidence is accumulating which indicates that when a coronary attack occurs, involving the major arteries of the heart, it may be the result of poor circulation mechanics rather than of diet and blood chemistry.

Conductors on London buses, one study showed, had a lower rate of fatal heart attacks than bus drivers. The rate for postmen was lower than that for telephone operators.

A 1951 study revealed that as physical activity increased with occupation, the percentage of fatal heart attacks diminished. Only one-seventh of 6,000 deaths from fatal coronary attacks were men who did "heavy labor," while almost 40 percent of those who died were teachers, clerks, bankers, and administrative officials.

First Population-Wide Cancer Study Results Announced

Harold F. Dorn, M.D., National Institutes of Health, Bethesda, Md.—Results of the first population-wide study of cancer show that the disease has its maximum threat for women during their most useful, reproductive years, while it is more likely to occur in men when their productive usefulness is waning.

The study was based on 1948-49 National Cancer Institute population surveys of almost 15 million persons in 10 metropolitan areas of the United States.

The male starts life with a slightly greater risk of developing cancer than does the female. The first five years are the most dangerous ones in childhood for both sexes. From 5 to 15 years of age, children are relatively free from the threat of cancer. By the age of 20 the risk is as great again as it was at birth.

At the age of 35, twice as many females as males have malignant tumors, but the rate among women decreases after the usual age of menopause. By the age of 60 in whites and 70 in nonwhites, the greater risk has overtaken the men.

Shortage of Technologists May Affect Medical Care

Lall G. Montgomery, M.D., Muncie, Ind., Chairman, Board of Registry of Medical Technologists, American Society of Clinical Pathologists—The present high quality of medical care may be seriously affected unless more medical technologists can be found to do the vital work of the laboratory.

In 1952 there was a shortage of 4,000 medical laboratory workers of all kinds. It was estimated then that in the five-year period from 1952 to 1957 hospital laboratories alone would require 10,000 additional medical technologists, while other employers would require at least another 7,000. To keep pace with these needs in the two years since these estimates were made, we should have added over 7,000 new certified medical technologists. Instead we added less than half that number during the two-year period.

Leonard A. Scheele, M.D., represented the government of the United States at the opening session of the International Congress.

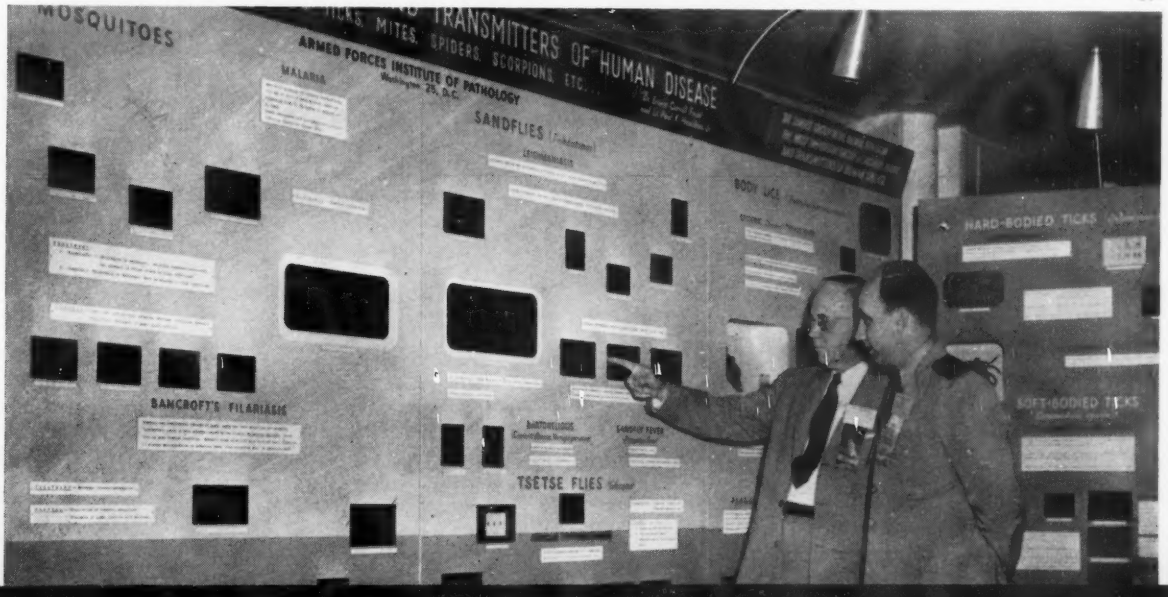
150 New Viruses Found By New Technics

R. J. Huebner, M.D., and W. P. Rowe, M.D., National Institutes of Health, Bethesda, Md.—New tissue culture technics have made it possible for us to find and grow 150 viruses previously hidden in tonsils and adenoids. The organs were removed and kept alive for periods up to two months in laboratories.

Eventually the tissue cells began a unique degeneration which removed a substance that apparently inhibited the growth of the hidden viruses. When the inhibiting substance degenerated, the viruses were unmasked as they began to grow and multiply.

Some of the newly-identified viruses have been found in respiratory diseases, including pneumonia. Discovery of the human tissue method of growing viruses may make it possible to develop vaccines or other protective agents against the diseases.

Ernest C. Faust, M.D., professor of tropical diseases and hygiene, Tulane University, New Orleans, and resident consultant, Armed Forces Institute of Pathology; and Lt. Paul Hamilton, U. S. Navy, chief of education and training, Armed Forces Institute of Pathology.



Topics Reports on . . .

American Association of Blood Banks

DOCTOR!
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BLOOD BANKS of the UNITED STATES
THE AMERICAN ASSOCIATION OF BLOOD BANKS CAN HELP YOU WITH YOUR
DOCTOR!
DO YOU HAVE A COMMUNITY BLOOD BANK?

Mrs. Bernice Hemphill, San Francisco, treasurer, chats with J. J. Griffitts, M.D., Miami, Fla., new president-elect. Dr. Griffitts is associate director, Blood Bank of Dade County, Miami, Fla., and associate director, Medical Research Foundation of Dade County.

● Authorities on blood banking called for the establishment of a nationwide "clearing house" system for blood collection at the recent meeting of the American Association of Blood Banks, held in Washington, D. C.

The system would be based on the clearing house principle employed in world banking. Under this plan, now in operation in some areas of the country, a blood "deposit" or donation could be made anywhere in the country and credited to an individual, his family, or anyone else designated. In times of disaster, it would make possible the collection and rapid shipment of large quantities of blood to acute areas.

Action on the plan was deferred for further consideration. Following are abstracts of some of the papers presented at the meeting.

Aaron Kellner, M.D., outgoing president, thanks Merlin L. Trumbull, M.D., new president, who presented Dr. Kellner with the past-president scroll. Dr. Trumbull is chief of pathology and director of laboratories, Baptist Memorial Hospital, and assistant professor of pathology, University of Tennessee Medical School, Memphis.

Whole Blood Needs in Enemy Attack

Val Peterson, Federal Civil Defense Administrator, Washington, D. C.—To meet the potential national need for whole blood in case of an enemy attack, we must expand facilities outside the areas of probable severe damage. A recent AMA survey of blood banks indicates that two-thirds of all existing collection facilities are in prime target areas.

Our aim must be to set up in advance a reasonably safe capacity to produce 47,000 units of whole blood an hour. To accomplish this aim, all existing whole blood collection facilities must prepare to triple their normal capacity in an emergency. Each should recruit and train additional personnel for a two- or three-shift, 24-hour

operation. Each should prepare a reserve of expendable supplies to sustain operations for at least eight to 10 hours under attack conditions. Each should select and equip on an improvised basis an alternate site for emergency operations, if the current location is dangerous or its space too limited.

All blood collection facilities should be catalogued in terms of their ability to be activated quickly. Quotas should be established and plans made for transporting the blood to medical installations as it is collected. Each standby emergency operations site should be equipped and staffed in safe but accessible areas.

Emergency standby facilities should be geared to handle 100 donors an hour, with capacity to bleed 20 donors simultaneously.

But having the necessary facilities available is not enough. We must have enough donors and enough experienced processors. Therefore, we must maintain a widespread public habit of blood donations, and must continue also the widespread training of auxiliary personnel to collect, process, and administer whole blood.

Platelet Thought Cause of Hemostatic Defect in Patients Receiving Dextran

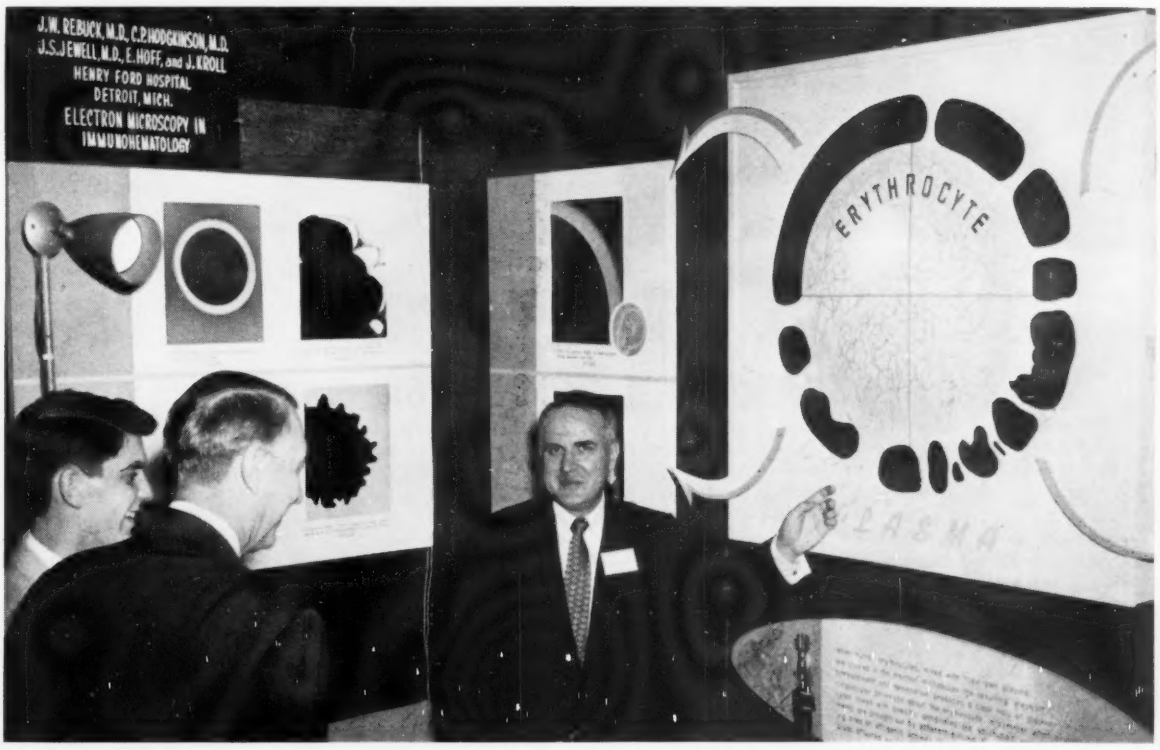
Capt. Edward Adelson (MC), Department of Hematology, Army Medical Service Graduate School, Washington, D. C., and Cpl. William H. Roeder, Army Medical Service, Washington, D. C.—Further studies on the prolonged bleeding time in patients who receive large amounts of commercially available dextran point to the platelet as the cause of the defect.

We found that with the prolonged bleeding time, patients develop a positive tourniquet test without significant thrombocytopenia. Dogs made moderately thrombocyto-

(Continued on next page)

Above: Israel Davidsohn, M.D., makes special award to Reuben Ottenberg, M.D., professor of medicine, Columbia University, for his outstanding contribution to the development of blood transfusions and preservation of blood. Dr. Davidsohn himself received the Ward Burdick award of the American Society of Clinical Pathologists at the meeting of the International Congress of Clinical Pathology, which was also held recently in Washington, D. C.

John W. Rebuck, M.D., Henry Ford Hospital, Detroit, explains his exhibit on "Electron Microscopy of Sensitized Human Red Cells."



O. B. Hunter, Jr., M.D., director, Oscar B. Hunter Memorial Laboratory and Blood Grouping Laboratory, Washington, D. C., and instructor in hematology, Georgetown University, Washington, D. C.; and Val Petersen, civil defense administrator, stand before the Federal Civil Defense Association exhibit. Dr. Hunter was elected vice president of AABB.

penic by x-ray became extremely sensitive to the dextran effect. The one patient most sensitive to the action of dextran on bleeding time was moderately thrombocytopenic. High molecular weight dextran, which is most effective in producing this hemostatic defect, also has a direct clumping action on the platelets in vivo and in vitro. The thrombocytopenia produced, however, is much more transient than the prolonged bleeding time.

Seegers has pointed out that dextran in vitro causes poor prothrombin consumption. Our studies indicate that this defect is probably due to an alteration of the platelet and not to a change in the plasma.

Kell Factor Immunization Increases

Jane M. Haber, Serologist, Central Laboratories, The New York Hospital and Cornell Medical Center, New York City, and Jacqueline B. Wehman, Assistant Serologist, The New York Hospital—The growing use of multiple blood transfusions has led to an increasing incidence of immunization to the Kell factor. Antibodies to this factor have been detected in 12 individuals during an 18-month period in a routine hospital blood bank.

Since these antibodies can cause erythroblastosis fetalis and serious transfusion reactions, and since they can be detected in many cases only by the indirect Coombs technic, we suggest that this procedure be incorporated into the routine cross-match.

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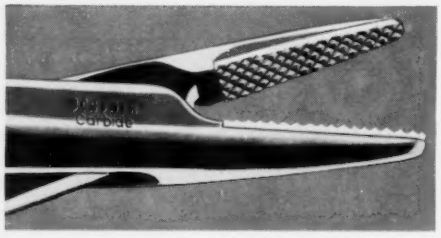

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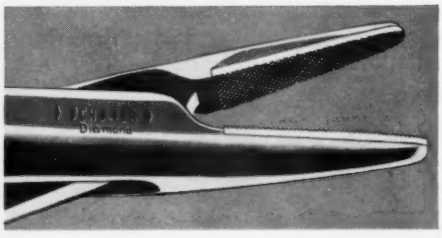

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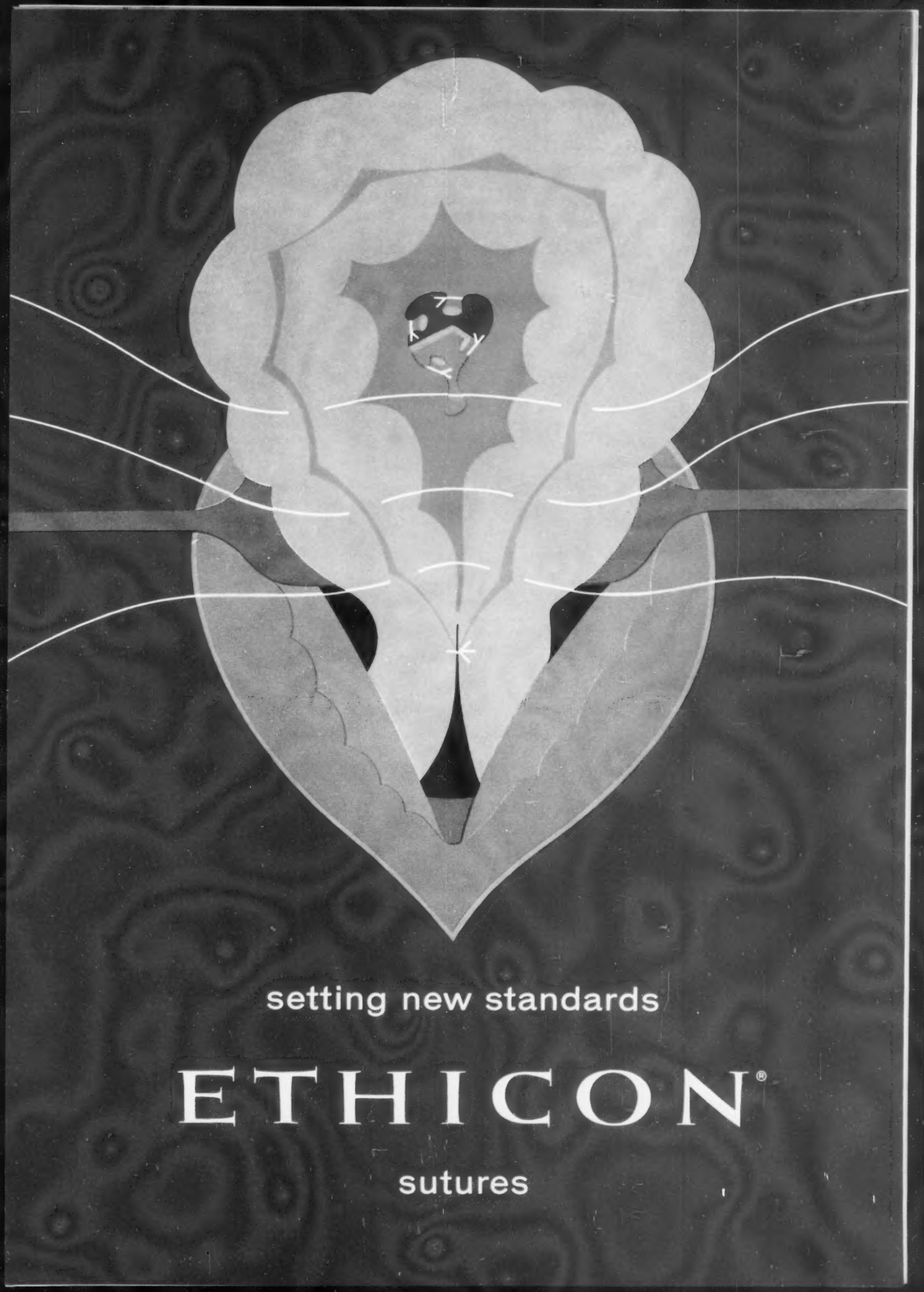
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Massachusetts Group Meets in Beverly

The semi-annual meeting of the Massachusetts Association of Medical Technologists was held October 30 at the Beverly (Mass.) Hospital, under the sponsorship of the Essex County Medical Technologists' Association.

The program featured a blood bank seminar, with Donald Brown, M.D., pathologist, Beverly Hospital, as moderator. Dr. Brown spoke on the administrative aspects of blood banking. John G. Gibson II, M.D., research associate, Harvard Medical School, Boston, discussed the use of separated red blood cells and plastic equipment.

"The Problem of the DU" was the subject of the talk by Alan Richardson Jones, M.D., assistant director, Blood Grouping Laboratory, Children's Hospital, Boston. Morten Grove Rasmussen, M.D., director of the blood bank, Massachusetts General Hospital, Boston, talked on "Blood Group Serology and Its Practical Aspects in Blood Transfusion Work."

At the afternoon session, Luke Gillespie, M.D., consultant obstetrician, New England Deaconess Hospital, Boston, and assistant obstetrician, Boston Lying-In Hospital, discussed afibrinogenemia, and Harry Shwachman, M.D., assistant professor of pediatrics, Children's Hospital, Boston, spoke about pancreatic function tests.

Louis DeLaura, M.T. (ASCP), Truesdale Hospital, Fall River, Mass., is president of the group. Barbara Staples, M.T. (ASCP), Union Hospital, Lynn, Mass., is program chairman.

Texas Names Chubbuck Outstanding MT

John William Chubbuck, M.T. (ASCP), editor of the news letter of the Texas Society of Medical Technologists, has been selected as the most outstanding Texas medical technologist of the year by his state society.

He received the award for establishment of the news letter. A graduate of the University of Texas School of Medical Technology, John Sealy Hospital, Galveston, Tex., Mr. Chubbock is employed in Tyler, Tex.

Postgradute Courses Planned

The annual postgraduate course in medical technology will be held in January, 1955, at the University of Kansas Medical Center, Kansas City. Lee H. Leger, M.D., pathologist at the center, is in charge of the course.

Another postgraduate course will be given in Denver, Colo., March 16-19, 1955, under the joint sponsorship of the University of Colorado and the Colorado Society of Medical Technologists.

Connecticut Society Elects New Officers

The Connecticut Society of Medical Technologists recently elected new officers for the 1954-1955 term. They are Mrs. Jean Sassano, Stamford Hospital, president; Carl Ritter, Milford Hospital, president-elect; Theresa Grillo, Grace-Haven Community Hospital, secretary; and Jessie Erwin, Rocky Hill, treasurer.

Wichita Technologists Aid In Polio Work

Medical technologists in Wichita, Kan., participated in the national polio vaccine program by donating their time and skill in bleeding first, second, and third grade children.

Samples were taken in May and again in the latter part of June.

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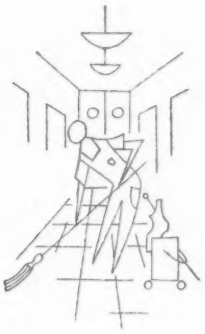

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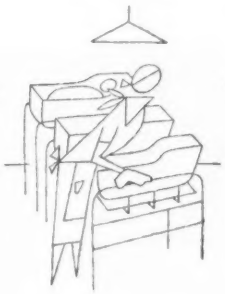
bactericidal—fungicidal—tuberculocidal action persists for a minimum of a week[1]

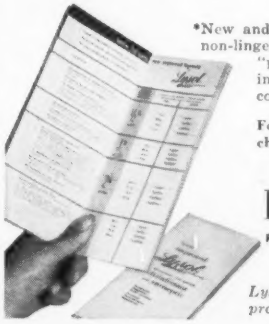


Lysol acts rapidly and efficiently, destroying all common pathogenic organisms even in the presence of organic matter such as dried sputum, pus or other body exudates.[2,3] Not only floors, walls, and furniture but dishes and utensils used by patients or in the laboratory, plumbing facilities, instruments, thermometers, and rubber or plastic goods can all be economically disinfected by Lysol. Cost in 1:100 use dilution, as recommended for floors and walls, is as low as 2.7 cents a gallon.

1. Klarmann, E. G.; Wright, E. S., and Shternov, V. A.: Prolongation of the antibacterial potential of disinfected surfaces, Applied Microbiology 1:19 (Jan.) 1953.

2. Smith, C. R.: Disinfectants for tuberculosis hygiene, Soap and Sanitary Chemicals 27:130 (Sept.) 1951; 27:145 (Oct.) 1951.

3. Klarmann, E. G.; Wright, E. S., and Shternov, V. A.: In vitro studies relevant to control of secondary reservoirs of respiratory pathogens. Am. J. Pharm. 123:42 (Feb.) 1951.



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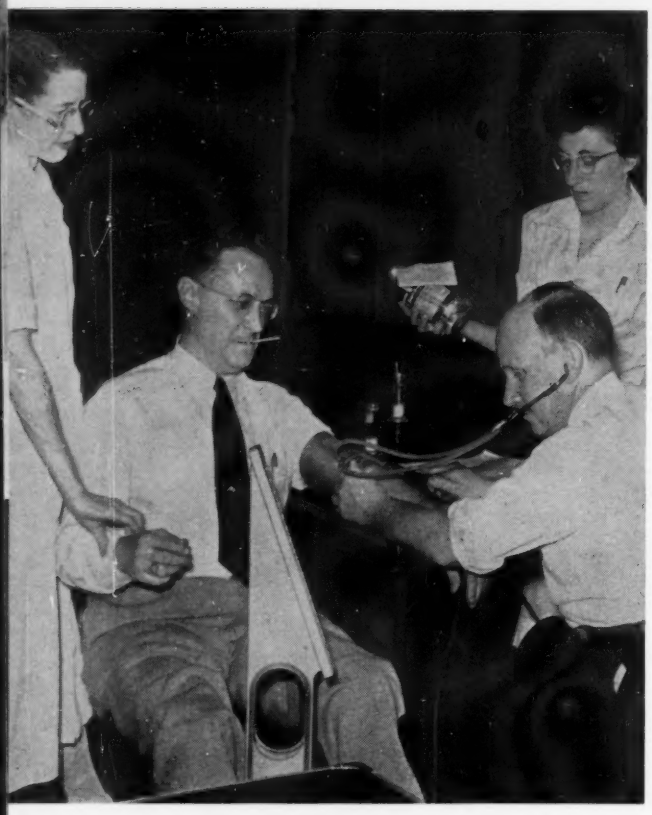


At left, Rev. Russel Moore, pastor of the First Baptist Church, Batavia, N. Y., receives his check-up at Genesee Memorial Hospital from George S. Young, M.D., president of the Genesee County (N. Y.) Medical Society, prior to subscribing pint of blood. Assisting Dr. Young are Lora Miller, R.N. (l.), taking pulse and temperature, and Mrs. Paul Niebch, technician. See story below.

Inaugurate New Blood Bank Program

One thousand three hundred and sixty-four persons subscribed one pint of blood each to join the pilot project of the Blood Assurance Program sponsored by Genesee Memorial and St. Jerome Hospitals, Batavia, N. Y., and the Genesee County Medical Society in affiliation with the non-profit Blood Banks Association of New York State. Subscription guarantees husband, wife and children under 21 years of age four pints of blood each, when needed, for one year. No charge is made to the donor or to his dependents.

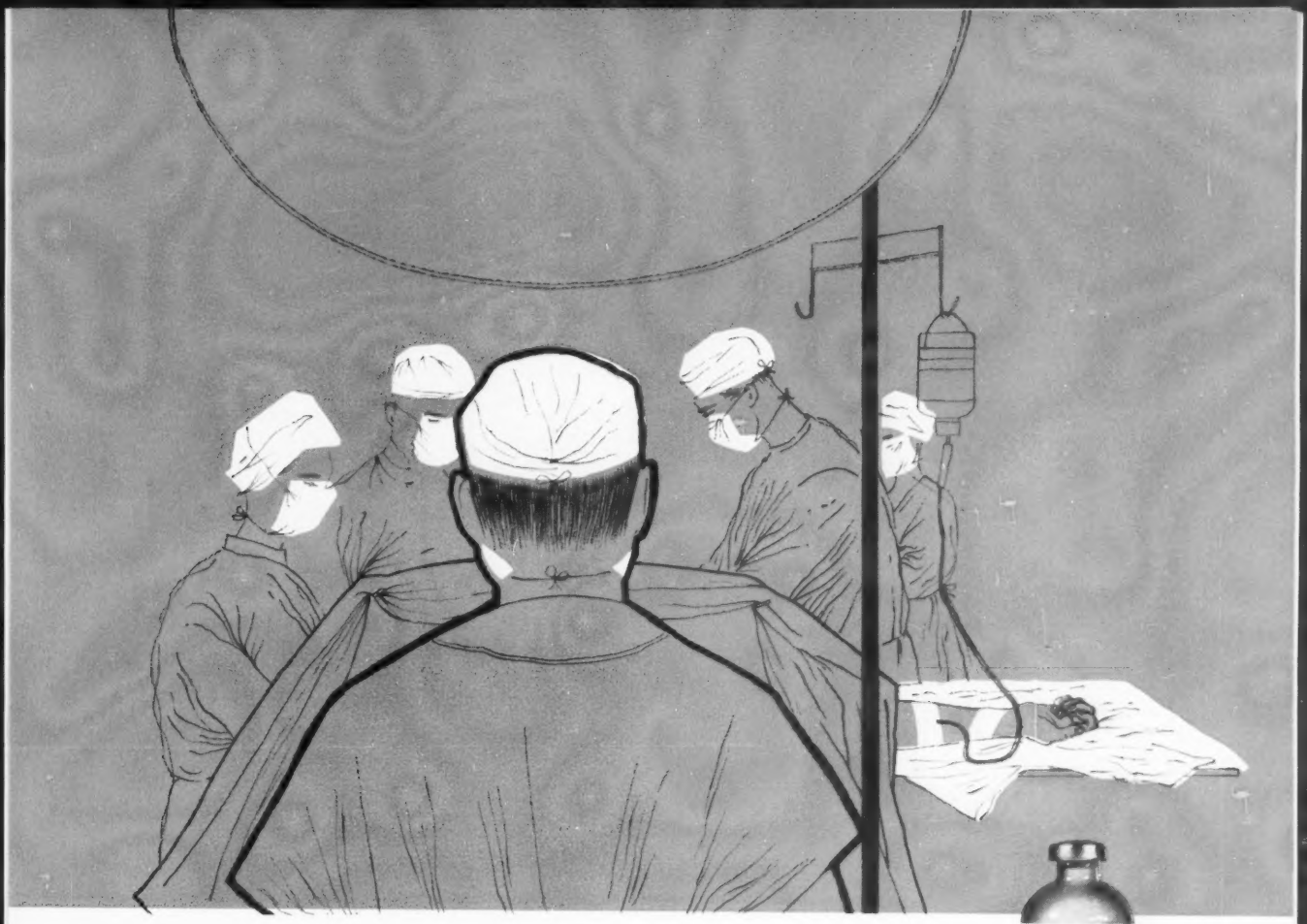
Central Issues Booklet On Equipping Lab

A booklet containing information on equipping a hospital laboratory is available from Central Scientific Co., 1700 Irving Park, Chicago.

The bulletin, No. 202, gives suggested equipment and supplies for 50-bed, 100-bed, and 200-bed hospitals. Items suggested are based on lists furnished by the U. S. Public Health Service.

Equipment lists are classified into three groups: capital equipment usually specified in the construction contract; equipment that becomes depreciable after five or more years, and equipment that becomes depreciable within five years (mainly low-cost items).

Below: Busy laboratory at 300-bed Tampa Municipal Hospital does 14,000 to 15,000 tests a month—as many as the average 600-bed hospital. Principal reasons for heavy load are very short average patient stay and high number of outpatient cases on whom tests are done. Laboratory staff includes 11 full-time technologists and one who comes in on Sundays. Shown here are (l. to r.): Linda Coniglio, M.T.; Angie Vacanti, M.T.; Patricia Stary, M.T.; Annie F. Smith, M.T., head technologist; and Katherine Neas, M.T.



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1. Helrich, M.; Papper, E. M., & Rovenstine, E. A.: *Anesthesiology* 11:33, 1950. 2. Stephen, C. R., & Martin, R.: *North Carolina M. J.* 12:501, 1951. 3. Phillips, H. S.: *Anesth. & Analg.* 32:56, 1953.

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Comparatively low vasomotor response to UROKON 30% was reported in a study comprising 2952 cases at Massachusetts General Hospital. Another medium produced *fifteen times* as many vasomotor responses as UROKON 30%[3].

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[1]Nesbit and Lapides. Univ. Michigan Med. Bull. *16*:37-42 (1950).
[2]Richardson and Rose. J. Urol. *63*:1113-19 (1950).
[3]Robbins, Colby, Sosman and Eyler. Radiology *56*:684-688 (1951).
[4]Neuhaus, Christman and Lewis.
J. Lab. Clin. Med. *35*:43-9 (1950).

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Their Aim's the Same

Mr. Purchasing Agent and Mr. Salesman

By Robert J. Heckel

CREATION OF A MORE WHOLESOME relationship between the hospital supply salesman and the hospital purchasing agent is necessary if both are to concentrate on their common goal—continuous improvement of the welfare of the hospital for the ultimate benefit of the patient.

Since the over-all welfare of the hospitalized patient is, in the last analysis, the primary objective of both purchasing agent and salesman, any factor which belittles the respective functions of either can jeopardize the progress of the hospital, and possibly even endanger patients' lives.

Although it is true that many salesmen are unworthy of the privilege of calling upon hospitals at all, we are concerned here only with those salesmen and purchasing agents who aspire to the professional class.

Neither price alone, quality alone, service alone, personal relationship alone, nor any given standard alone, can justify purchase of any given product. It is rather the right combinations of these elements, plus many more, which, when sifted carefully by both P.A. and salesman, evolve into the correct answer as to what will best benefit the hospital. How can this lofty ideal come into being unless both parties meet on a common ground of mutual confidence and respect?

We can start by analyzing the backgrounds of hospital purchasing agents and hospital salesmen. Both are trained to cope with hospital supply problems. Both are trained with an eye toward quality and a sense of practical economy. Both have, as their ultimate goal, the continuous improvement of the hospital.

It would seem from the above that the aims of the P.A. and the salesman are actually identical. Therefore, the ill feeling commonly found between them would seem to be unfounded in fact. Yet how many times does an overburdened buyer wish he wouldn't see a salesman for a week, because of the demands of other duties—many of them not truly the duties of a purchasing agent?

Where the purchasing office has "grown like Topsy" so that "normal" routine includes such activities as payroll, personnel, and accounting, the true functions of the department become hazy and ill-defined. It is then that some phase of the purchasing function must be sacrificed. That phase, more often than not, is the practice of interviewing salesmen. To this type of purchasing office, the salesman automatically becomes the proverbial pest.

How many thousands of dollars of potential savings go down the hospital drain each year because purchasing agents haven't time to listen to what may be a tangible, effective idea of a sales representative? Of course, it is the responsibility of the salesman, on the other hand, to make sure he has something worthwhile to say.

An executive of the Ford Motor Co. published an article a few years ago stating that he expected his purchasing agents to honor and respect visiting salesmen. As a result of establishing this policy, he said, he anticipated an increase of several million dollars in Ford profits.

Is this far-fetched reasoning? Not at all, when one realizes that millions of dollars are expended annually in research by salesmen's employers who are seeking improved quality and better production. The fruits of this research can be turned to practical use when disseminated through the lips of the sales representative.

It would be ridiculous to advocate changing products daily in a never-ending effort to keep abreast of the times. However, it is equally fallacious to assume that because a given product has met the standard requirements for two decades, it must still be the best today. Every solid American enterprise is continually on the lookout for the better product, the better method, the more economical balance, and it behooves both purchasing agent and salesman to continually weigh the facts, then come to a sound businesslike decision.

Price is on everyone's mind—the salesman's as well as the purchasing agent's. But here again the necessity for improving relations between the two must be emphasized. Too often what could have been an enlightening interview ends abruptly and mysteriously when the question of price is raised.

Certainly, it can easily be proved that the word "price" more often than not is actually an imaginary, intangible term. This is not said facetiously. Price is a number title given to a quantity of goods. It tells nothing about durability, usefulness, safety, convenience, labor-saving, acceptability, or over-all quality! Therefore, price can take on true significance only after the over-all attributes of the respective products have been carefully measured.

The final step, then, is to set the price in ratio to the usefulness of the product and thus to arrive at what the purchasing agent is sincerely seeking—namely, the cost of the product *in use*. Although not a difficult concept to comprehend, it is the one most commonly ignored.

Sometimes the purchasing agent purposely avoids the more economical product because he feels that the economy is only theoretical and "won't work in this hospital because no one really cares about economy anyway." Here again, through improved understanding between P.A. and salesman, the hospital can tap the latent benefits of theory and put them to practical use in the form of savings and improved methods.

The professional hospital salesman today has been trained not only to know his product but to be proficient in teaching others of its merits and proper use. He is usually capable of conducting a complete survey and educational program on behalf of the hospital. Hence, the modern professional salesman is in a very real sense a direct consultant of the purchasing agent. If the salesman cannot supplement the energies and abilities of the purchasing agent by attempting to sell products which are of tangible benefit to the hospital and patient, he does not qualify in the professional ranks. An "order taker" performs no service. He is a costly parasite on all society.

Whenever a professional purchasing agent and a professional salesman confer on a given hospital problem in a spirit of confidence and mutual respect, the single objective of what is economically best for the hospital and for the patient is obviously a matter of concern to both. Given this attitude, a proper conclusion as to what product should be purchased will evolve in a logical fashion, with a minimum of time-consuming, suspicious haggling.

Mr. Heckel is associated with the Professional Products Division, Lehn & Fink Products Corp.

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Ten Years of Surgical Practice In a Rural Hospital

By the Medical Staff
Glenwood Community Hospital
Glenwood, Minn.

The following article is reprinted from GP, Vol. 10, No. 1, July, 1954, *with permission of the publisher. It presents details of a plan for providing special surgical consultants for a small rural hospital. Statistical material was compiled by Joanne Dow Waldron, R.R.L., Minnesota Department of Health.*

THE GENERAL PRACTITIONER in a small rural hospital has three choices in deciding how his patients should be treated surgically. First, he may refer the more major cases to a metropolitan area. Second, he may undertake a program that will bring specialized care to the rural area through the use of consulting surgeons. Third, he may attempt to do all but the most highly specialized procedures himself. This last course seems illogical in view of the high degree of surgical specialization and is inconsistent with the effort to give everyone the best possible surgical care.

With the emphasis today on the decentralization of medical care, as evidenced by the nationwide hospital construction program, the trend is toward development of a program that will bring consulting surgeons to the rural area. Communities large enough to support a modern hospital, with complete facilities and services, are encouraged to build. Under this program new hospitals in the rural areas are equipped to allow the performance of all but the most difficult surgical procedures. The people in these communities, through their contributions to building programs, have become aware of the hospital's potentials and want to make the best use of them.

Confronting the general practitioners who staff these new small hospitals are the questions as to whether or not consulting service should be adopted, and, if adopted, as to how the consulting surgeons may be used most effectively. The staff of the Glenwood Community Hospital was called upon to face this problem twelve years ago. Due chiefly to the thinking of certain members of the original group, the staff gradually adopted one particular method—that of bringing surgical consultants to the patients in the local community.

Bringing the consultant to the patient instead of the patient to the consultant was an idea that aroused much local criticism. It was said that eventually people would require a specialist to perform even the simplest procedures, leaving nothing for the family physicians. It was found, however, that by staying at home for hospitalization, patients saved themselves the cost of travel to other places and often avoided higher hospital rates. Their worries were lessened by the presence of family and friends and a familiar environment. More and more patients came in for diagnosis and treatment as they became aware that expert help would be called whenever it was needed.

As time went on, another important point became evident. As the local staff men worked with consulting specialists, they became familiar with many points of diagnosis, surgical procedures of choice, and the technics of postoperative care. This knowledge was invaluable in preparation for more skillful management of the emergency case that demands immediate care, thus lending justification to this method of approach.

The general modus operandi of the policy is briefly as follows: The Glenwood Hospital staff members perform all surgery such as appendectomies, hemorrhoidectomies and herniorrhaphies. In addition, the local men perform all acute emergency procedures of the more major type. In this category fall such operations as Cesarean sections, emergency colostomies, or bowel resections. For the more major elective surgery, the staff secures the services of specialists who come to the hospital when called upon to do so.

To assist in making this program run smoothly, the staff attempts to employ well-trained laboratory personnel and engages the services of a competent roentgenologist who visits the hospital weekly to perform fluoroscopic studies and to interpret x-rays that have accumulated during the week. In addition, a close relationship with specialists in the larger centers is maintained so that particularly difficult diagnostic problem cases may be sent to them for consultation when necessary.

The problem of anesthesia has been solved by the use of open drop ether anesthesia, spinal anesthesia, local anesthesia, and more recently thiopental sodium intravenously. In cases that require more difficult surgery, a trained anesthetist accompanies the surgeon from the metropolitan center.

To the staff members, the consulting service is an in-service training aid and a stimulus to the use of thorough diagnostic methods. As they work closely with specialists, they find themselves also asking help of each other. It has become increasingly easy for the members to write regulations for themselves, to criticize each other in a constructive manner, and to make weekly staff meetings more valuable through the analysis of cases. They feel it improves the medical records.

Since its organization in 1940, the staff of the 26-bed Glenwood Hospital has been comprised of from four to eight general practitioners, and has functioned under rules and regulations laid down by the hospital board and staff. For slightly more than ten years then, board men (consulting surgeons) have come 120 miles to this hospital from Minneapolis to give consultant service in their specialties. They usually perform several procedures during the day, assisted by the general practitioners of the staff. Occasionally the consulting surgeon's diagnosis does not agree with that of the local practitioners, in which case the specialist refuses to operate and other

(Continued on next page)

methods of treatment are advised. The fact that these same consulting men continue to return year after year is evidence that they are satisfied with this approach.

THE MEASURE OF SUCCESS

Though the staff feels that this approach to surgical cases has been very satisfactory, it realizes nevertheless, that the profit of success lies in the results of the treatment as indicated on the medical records. This article, therefore, represents an attempt to measure objectively the findings of a study of surgical cases cared for at the Glenwood Community Hospital for the 10-year period beginning September 30, 1942, and ending September 30, 1952.

During the ten-year period, there were 11,523 discharges from the hospital. Of this total, 1,038 (9 percent) were classified as major surgical cases. An arbitrary definition of major surgery was used, and the types of cases can be

(Continued on page 26)

TABLE I

TYPES OF OPERATIONS PERFORMED DURING TWO FIVE-YEAR PERIODS AT GLENWOOD HOSPITAL, GROUPED ACCORDING TO FINAL DIAGNOSIS.

Name of Operation	1942-1947	1947-1952	Total
1. Appendectomy, with	159	161	320
Excision ovarian cyst	2	2	4
Excision cyst of tube	1	—	1
Incision and dr. ovarian cyst	1	1	2
Salpingectomy	1	1	2
Tubal ligation	1	—	1
Circumcision	1	—	1
Hemorrhoidectomy	—	1	1
Salpingo-oophorectomy	—	1	1
Oophorectomy	—	1	1
2. Cholecystectomy, with	61	84	145
Choledochotomy	1	2	3
Choledocholithotomy	4	4	8
Choledochostomy	1	2	3
Liver biopsy	—	1	1
Liver resection	—	1	1
Choledocholithotomy	2	—	2
Cholecystogastrostomy	1	—	1
Choledochoduodenostomy	—	1	1
Exploratory, with	1	3	4
Excision of gallbladder stump	—	1	1
3. Hysterectomy	14	45	59
Vaginal hysterectomy	—	2	2
Myomectomy	2	2	4
Cystocele, rectocele repair	2	3	5
Salpingectomy, oophorectomy and salpingo-oophorectomy	22	19	41
Hysteropexy	3	2	5
Cesarean	1	5	6
Oophorecystectomy	9	6	15
Laparotomy	13	3	16
Ligation of tube	2	5	7
Repair and suspension	—	1	1
4. Transurethral resection with	33	20	53
Vasectomy	1	1	2
Vasectomy and lithotomy	1	—	1
Suprapubic prostatectomy	—	1	1
5. Nephrectomy	4	3	7
Exploratory of left kidney	—	1	1
6. Cystolithotomy	1	1	2
Cystotomy	1	3	4
Ureterolithotomy	—	2	2
Totals	346	392	738

(Continued in next column)

Name of Operation	1942-1947	1947-1952	Total
7. Herniorrhaphy, elective	70	65	135
Herniorrhaphy, strangulated	4	—	4
Herniorrhaphy with			
Rectocele repair	1	—	1
Excision tumor testes	1	—	1
Ligation tube	1	—	1
Orchidopexy	1	6	7
Excision undescended testes	—	1	1
Cordectomy, orchidectomy	—	1	1
Excision ovarian cyst	—	1	1
Transurethral resection	—	1	1
Decompression bowel	—	1	1
Excision cyst rd. ligament	1	—	1
Exploratory	—	2	2
8. Gastrectomy	2	1	3
Closure peptic ulcer	3	4	7
Gastroenterostomy	1	—	1
Enterostomy	4	2	6
Cecostomy	1	—	1
Reduction of intussusception	1	—	1
Colostomy	8	4	12
Intestinal resection	1	5	6
Exploratory laparotomy	4	7	11
Closure fecal fistula	2	—	2
Drain abscess, appendix	1	1	2
Splenectomy	1	—	1
Pyloromyotomy	1	—	1
Diverticulectomy	—	2	2
Incision and drainage, cyst of pancreas	—	1	1
Removal of foreign body	—	1	1
Enterolysis	—	1	1
Cholecystogastrostomy	—	1	1
Cholecystoenterostomy	—	1	1
9. Open reduction	13	29	42
Excision of knee cartilage	—	2	2
Excision of knee tumor	1	—	1
Amputation of leg	—	1	1
10. Mastectomy	6	8	14
Excision of breast tumor	1	—	1
11. Thyroidectomy	4	17	21
Total	134	166	300
Grand Total	480	558	1038

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TABLE 2
MAJOR SURGERY AT GLENWOOD HOSPITAL OVER TWO FIVE-YEAR PERIODS, 1942-1947 AND 1947-1952, BY STAFF GROUPS.

Name of Operation	1942-1947				1947-1952				
	Operations by Attending Staff	Operations by Consulting Staff	Number of Attending Staff Present*	5-Year Total	Operations by Attending Staff	Operations by Consulting Staff	Number of Attending Staff Present*	5-Year Total	10-Year Total
1. Appendectomy	161	15	170	166	161	7	171	168	334
2. Biliary Tract Surgery	10	61	131	71	4	95	177	99	170
3. Pelvic Surgery	37	31	98	68	30	63	138	93	161
4. Prostatectomy		35	36	35		22	23	22	57
5. Kidney Surgery		4	7	4		4	7	4	8
6. Other GU Surgery	2		1	2	4	2	9	6	8
7. Herniorrhaphy	59	16	89	79	64	14	81	78	157
8. Gastrointestinal Surgery	10	20	44	30	14	17	51	31	61
9. Open Reduction	7	7	16	14	10	22	36	32	46
10. Mastectomy	1	6	11	7		8	15	8	15
11. Thyroidectomy		4	7	4		17	26	17	21
Total	277	199	610	480	287	271	734	558	1038

**Excluding surgeon operating*

RURAL HOSPITAL continued

found in *Table 1*. The study was broken into two five-year periods so that trends resulting from the consulting service can be observed. From Table 1 it is evident that a wide variety of cases was treated over the ten-year period. The distribution of the different types of cases is not unusual. There is an obvious increase in the number of open reductions, pelvic operations, thyroidectomies, and cholecystectomies performed in the second five-year period.

Table 2 presents a comparison of the amount of work done by the consulting and attending staffs. It is interesting that the operations performed by attending men from one five-year period to the next increased slightly from 277 to 287, although the consulting surgeons also did more work. In the first five-year period, consultants performed 199 procedures as compared with 271 in the second five-year period. Referring to pelvic surgery, attending men performed seven fewer such procedures, whereas the consulting surgeons doubled their work from thirty-one to sixty-three operations. Yet an analysis of the total surgery performed reveals that the attending staff actually operated in more than 50 percent of the cases.

Full use has been made of the pathology laboratory for tissue diagnosis in all major surgical cases. In all categories there has been excellent agreement of surgical and pathologic diagnosis. A figure of 10 percent of supposedly non-pathological appendices is well within usual experience. The cases receive careful scrutiny routinely as a part of our Tissue Committee procedure.

A picture of the mortality and autopsy rates on major surgical cases in the hospital is presented in *Table 3*. A death rate of 2 percent is low. Moreover, if the breakdown is carried further, not all of these cases can be classified as postoperative deaths, since some of them died well over ten days postoperative. The autopsy percentage of 17 is considered good for a small hospital with no resident pathologist.

Tables were not set up for infections since the incidence of infections was almost nonexistent.

TABLE 3
DEATH AND AUTOPSIES OF THE MAJOR SURGICAL CASES AT GLENWOOD HOSPITAL FOR THE TWO FIVE-YEAR PERIODS, 1942-1947, AND 1947-1952.

Name of Operation	1942-1947			1947-1952		
	Died	Autopsied	Total Cases	Died	Autopsied	Total Cases
1. Appendectomy	0	0	166	1	0	168
2. Biliary Tract Surgery	2	0	71	1	0	99
3. Pelvic Surgery	1	0	68	2	1	93
4. Prostatectomy	0	0	35	2	0	22
5. Kidney Surgery	1	0	4			4
6. Other GU Surgery			2			6
7. Herniorrhaphy	2	0	79	1		78
8. Gastrointestinal Surgery	3	2	30	5	1	31
9. Open Reduction			14			32
10. Thyroidectomy			4			17
11. Mastectomy			7			8
Total	9	2	480	12	2	558
Percent	1.8	22		2	16.6	

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Medical Record Librarians Meet

● Registration reached 532 at the 26th annual meeting of the American Association of Medical Record Librarians, held October 4-8 in Detroit.

Marjorie R. Quandt, R.R.L., former director, School for Medical Record Librarians, Wesley Hospital, Chicago, was appointed the first education director for the group. Honorary membership in the association was bestowed upon George Bugbee, president, Health Information Foundation, New York City, and Edwin Crosby, M.D., executive director, American Hospital Association.

Among major projects approved for development during the coming year were a code of ethics for members, establishment of personnel policies for medical record librarians, and a study of problems inherent in organizing and administering medical record departments in chronic disease hospitals. Mental and tuberculosis hospitals were included in this category.

A session on advances in medicine included "Recent Advances in Endocrinology," by Grosvenor W. Bissell, M.D., chief of medical service, VA Hospital, Buffalo, N. Y.; "The Mechanical Heart," by F. D. Dodrill, M.D., surgeon, Harper Hospital, and chief of thoracic surgery, Mt. Carmel Mercy Hospital, Detroit; and "Drugs, Records, and You," by Albert H. Holland, Jr., M.D., medical director, Food and Drug Administration, Department of Health, Education, and Welfare, Washington, D. C.

Olive G. Johnson, R.R.L., National Institutes of Health, Bethesda, Md., discussed criteria and methods used in the organization of records for research. "Assembling Data Via the Punch Card" was the subject of Alma E. Blum, R.R.L., Niagara Sanatorium, Lockport, N. Y. Other discussions on research were presented by James T. Oliver, principal statistician, Department of Health, City of Detroit, and Cleo B. Nelson, R.R.L., VA Center, Los Angeles. Miss Nelson discussed "Statistics in Research."

Also featured at the meeting were consultation clinics on standard nomenclature, procedural manuals, the medical audit, terminal digit filing, budgeting, and group supervision.

Reports on hospital accreditation were given by Kenneth B. Babcock, M.D., director, Joint Commission on Accreditation of Hospitals, Chicago, and Franklin D. Carr, administrator, Detroit Memorial Hospital, who spoke from the administrator's point of view.

Executive board and executive personnel for 1954-55 are, front row (l. to r.): Dorothy L. Kurtz, Columbia-Presbyterian Medical Center, New York City, first vice-president; Eddie V. Cooksey, Charity Hospital, New Orleans, president-elect; Helen D. McGuire, U.S.P.H.S., Washington, D. C., president; and M. Loyola Voelker, U.S.P.H.S. Hospital, Baltimore, second vice-president. Back row: Marjorie R. Quandt, Chicago, education director; Sara McKinney, University of Pennsylvania Hospital, Philadelphia, director; Doris Gleason, Chicago, executive director; and Alta B. Mitchell, Mt. Sinai Hospital, Milwaukee, Justine Hanson, St. Barnabas Hospital, Minneapolis, E. Louise Seymour, New England Deaconess Hospital, Boston, all directors; and M. Elizabeth Murphy, VA Hospital, San Francisco, secretary.

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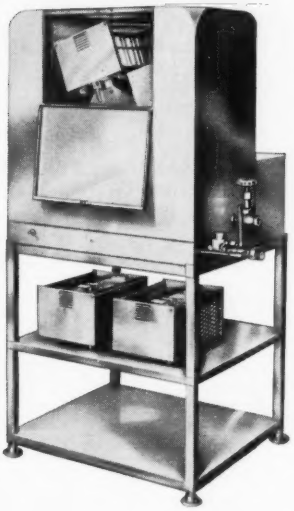

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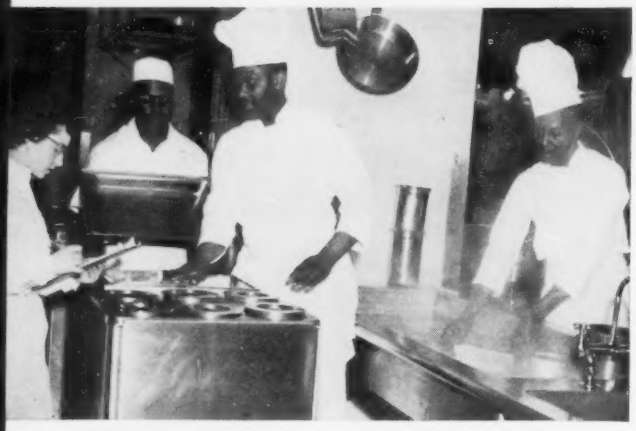
Marie E. Clark (l.), one of the dietitians in charge of two floors, and Miss Jones look over patient record cards.



Above: Eileen Kenny, dietitian in charge of main kitchen, checks food cart as it is loaded to go up to floors. Larry Barnes (second from l.), cart boy, waits for cart being prepared by Charles H. Harrison, cook in charge of the shift, and Paul Campbell, special diets cook. Below: Larry Barnes delivers food to floors.

● Suppose you had to make sure that a patient ate 30 grams instead of only 25 grams of beef, and that he received beef from the same piece of meat for three weeks —it would complicate dietary planning considerably. Yet Edith A. Jones is used to unusual requests because of the unusual needs of the research programs at the National Institutes of Health.

The story one patient tells is that three green peas dropped on the floor, and the dietitian went out and got three more. The records kept at the center are just about that accurate, too, when the staff is attempting to learn the effect of a specific diet on a patient. A patient may receive one-half or one-fourth of a cooky, for example, and he's asked to eat every crumb, if he is on a diet which must remain constant in weight and food values.

Every patient has a selective menu. The master menu is prepared so that a diabetic diet can be selected from it. The center also offers a liquid diet, a soft diet, and five different low sodium diets (and variations of amounts of sodium). In case the patient doesn't like anything on the regular menu, his dietitian knows she always can offer several substitutions.

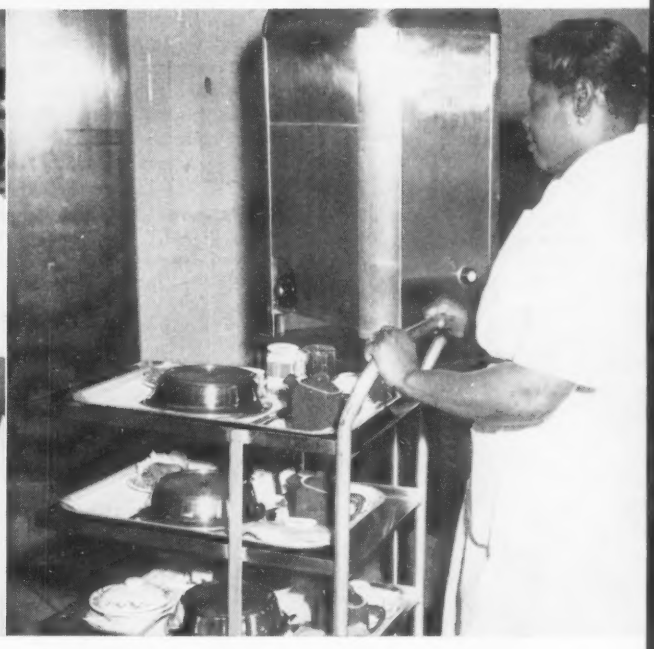
In addition to selective menus for every patient, the high percentage of calculated or weighed diets sets the center apart from the usual hospital. This percentage varies from institute to institute.

Yet, despite the special demands which the various institutes may make, the main kitchen of the center has no special diet kitchen attached. The meat cook who prepares the regular beef also does the salt-free beef, with excellent results, Miss Jones says. She cited as an example a patient who, when transferred to the center, had been on a low sodium diet but had not lost weight. Within a week he had lost five pounds.

Keeping the records on the various diets is speeded by use of a color system for record cards. The color of card indicates the kind of diet the patient should have. Salmon color, for example, means no salt. Green indicates a diabetic diet, low in calories, and red means nourishment at night. (Incidentally, nourishment between meals is discouraged unless the doctor orders it as part of a special diet.)

The dietitian sees the patient the first day he is admitted.

(Continued on page 32)



Top, left: Mary Little weighs hot food to make sure patient gets exact amount prescribed in diet. At right: Dora Little weighs milk for patient tray.

In center, at left: Annie G. Smith (l.) checks tray, as Dora Turner puts cold foods on it, and Mary Little adds the hot foods. At right: Food is taken to patients by the food service aides. Here Claudia Paige starts out to deliver several trays.

Right: Annie G. Smith weighs food left on patient's tray to report the exact amount to the dietitian, so that the daily intake record will be accurate.

A diet file card is maintained at this time and becomes a permanent record with the dietitian.

Daily diet slips must be in by 10:30 a.m. The food service aides have the responsibility of totaling the diet slips, and the total sheet goes to a dietitian for transfer to the main kitchen. One elevator is used for food service only.

The hospital has not one but five metabolic research kitchens. Another advantage, besides the number of kitchens, is the fact that the kitchens were designed specifically for the studies, whereas other hospitals have more or less improvised their metabolic units.

There are two sets of theories on metabolic studies. One advocates the three-day rotating diet; the other says the patient should eat the same thing every day. For either system, food must come from the same source (like one side of beef). Everything for each patient is cooked in an individual pan. Even coffee has to perk the same period of time, because the potassium content varies.

For short-term studies, the number of items permitted on diets is about 20. The units are equipped with cooking equipment, and all food preparation is done right in them. Food usually is prepared in small containers, and may often be served in the container in which it is cooked. Since the patient is required to eat everything on his tray, a very cooperative patient is essential. Cooking on the metabolic units consists primarily of broiling or steaming.

Master menus are planned two to three weeks in advance. The patients' regular menu is the basis for the menu in the employees' cafeteria.

If something different is to be placed on the menu, a menu conference is held to discuss how it is going to be prepared. After the menu conference, the menus are typed, and are also typed in another form for the cook's work sheets.

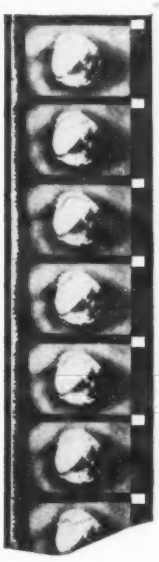
Food costs are broken down into 18 different groups, making it possible to trace down high costs in specific areas.

Adequate preparation before opening was a definite aid to smooth functioning of the department. The chief cook came one month ahead of time, and through close association with the dietitians, picked up their philosophy. Supervisors came in three weeks ahead, and the following week the people they were to supervise came in—but the supervisors were still kept separate. The first three days the "kitchen help" got the lay of the land, while supervisors went over teaching material and reported to dietitians. The last two days of that week, the kitchen help worked under their supervisors. Then the last week before the center opened, the staff did a "dry run."

When hot food was sent up to patient areas, the staff, serving one another, found out the food was cold. They practiced speeding up service. Heated plates help keep food warm.

Eventually all five kitchens will be in operation, with 10 patients in each. When HOSPITAL TOPICS visited the center, only two were open—one with four patients, one with one.

Below, left: Merme Bonnell (l.), dietitian in charge of a metabolic research kitchen unit, watches as Annetta Wright, helper, weighs rice for constant diet. Rice is often used because it provides much carbohydrate without much other food value. Torsion balanced scales are used in metabolic units because they provide highest degree of accuracy. At right: food on metabolic units usually is prepared in small containers and, consequently, may be served in same utensils.



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C I B A
SUMMIT, N. J.

2/2055H

Washington State Hospital Association Holds 22nd Annual Meeting

● About 375 hospital representatives attended the 22nd annual meeting of the Washington State Hospital Association in Yakima, September 29-30.

Highlights of the program were two panel discussions, one on safety and professional liability, and the other on working relationships between governing board, administrator, medical staff and the public.

A doctor should sit on the executive committee of the board of trustees of every voluntary hospital, in the opinion of Richard D. Reekie, M.D., chairman of the State Joint Commission on Improvement of the Care of the Patient. He said that such representation—even though the doctors might not have a vote—would improve the frequently poor liaison between the administration and the medical staff.

"I'm sure that no staff member wants anything to do with the actual management of the hospital, but he would like to have some say in the over-all direction of the hospital . . . and his opinion would be of value to administration and to the other trustees," Dr. Reekie stated.

Other panel members, including administrators and trustees, agreed on the need for good communication between the medical staff and the board, but not all agreed that having doctors on the board was better than a liaison conference committee.

Abstracts of two lectures presented at the meeting follow.

Responsibilities of the Hospital Trustee

Arnold A. Rivin, Editor of "Trustee," Chicago—While the doctor heads the team that provides patient care, with nurse and hospital administrator following close behind, the ultimate responsibility for the quality of patient care that is practiced in the hospital falls on the trustee.

The trustee's responsibility is such that he must insure proper care. If he does not, he is negligent and perhaps legally liable.

Principal functions of the trustee include seeing that his medical staff is organized, has self-government and has an adequate set of rules and regulations; and seeing, through his administrator, that these rules and regulations are adhered to.

It is also his duty to represent the hospital to the community by telling the people what the hospital is, what it is doing, and what it needs to do its job properly.

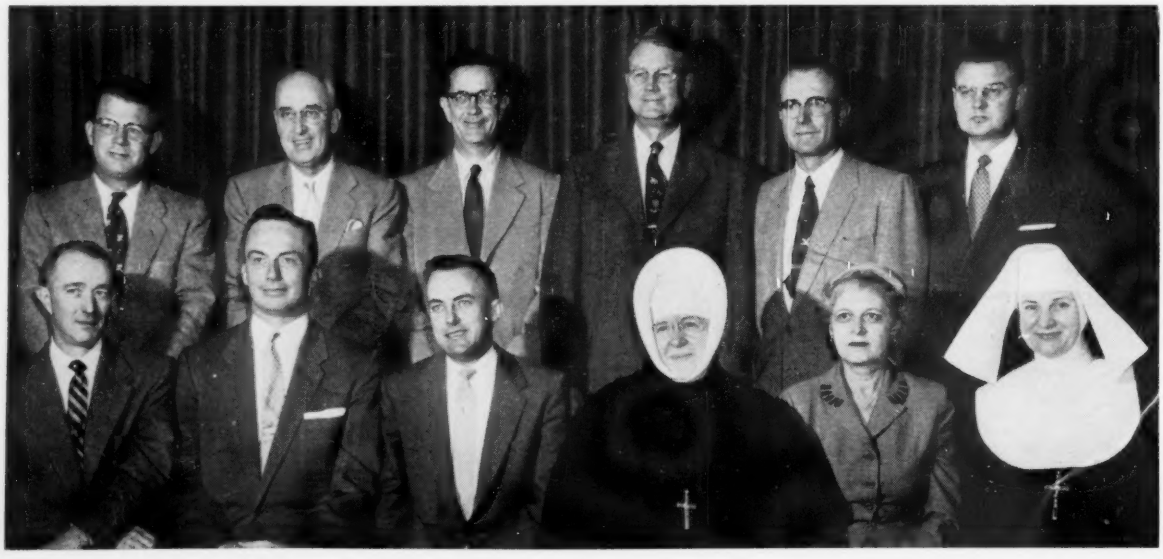
Developing a Policy for Handling Hospital Visitors

Ronald H. Orr, President, Washington State Hospital Association, and Manager, Grays Harbor Community Hospital, Aberdeen, Wash.—Visitors are a minor but important part of the complex business of running a hospital. More than 10,000 persons daily visit friends and relatives in community hospitals throughout the state of Washington. Some tips to hospital visitors are:

Don't sit on the patient's bed; don't smoke (even if the patient says he doesn't mind); if you bring a gift, be sure it is sensible; look pleasant and be cheerful, but don't put on a comic act.

Let the patient decide if he wants to talk about his illness, don't ask him; try to have good news to tell; don't tell your worries to the patient, and don't stay too long.

New officers and trustees of the Washington State Hospital Association are, seated (l. to r.): Ronald H. Orr, Grays Harbor Community Hospital, Aberdeen, past president; Paul S. Bliss, Vancouver Memorial Hospital, Vancouver, president-elect; Max L. Hunt, Yakima Valley Memorial Hospital, Yakima, president; Sister Agnes of the Sacred Heart, Providence Hospital, Seattle; Catherine Griffin, Maynard Hospital, Seattle; Sister M. Cyprian, St. John Hospital, Longview, first vice-president. Standing: W. John Dobyns, Tacoma General Hospital, Tacoma, trustee; Horace Turner, Deaconess Hospital, Spokane; Lawrence Trousdale, St. Luke's Hospital, Spokane, third vice-president; Martin N. Olsen, Swedish Hospital, Seattle, treasurer; Virgil W. Jackson, Samaritan Hospital, Moses Lake; and Orville Bakko, Kadlec Hospital, Richland, second vice-president. Sister Rose, St. Elizabeth Hospital, Yakima, trustee, is not shown.



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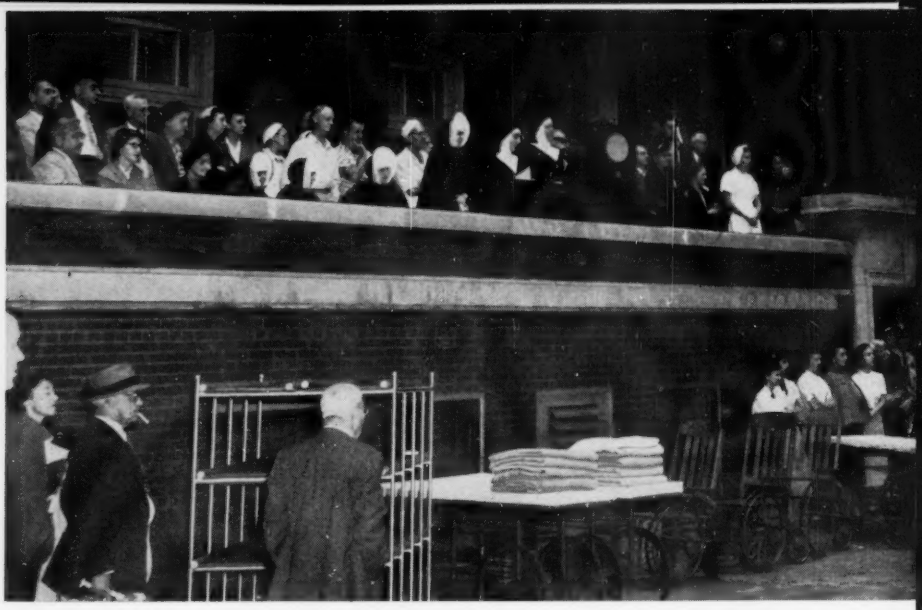
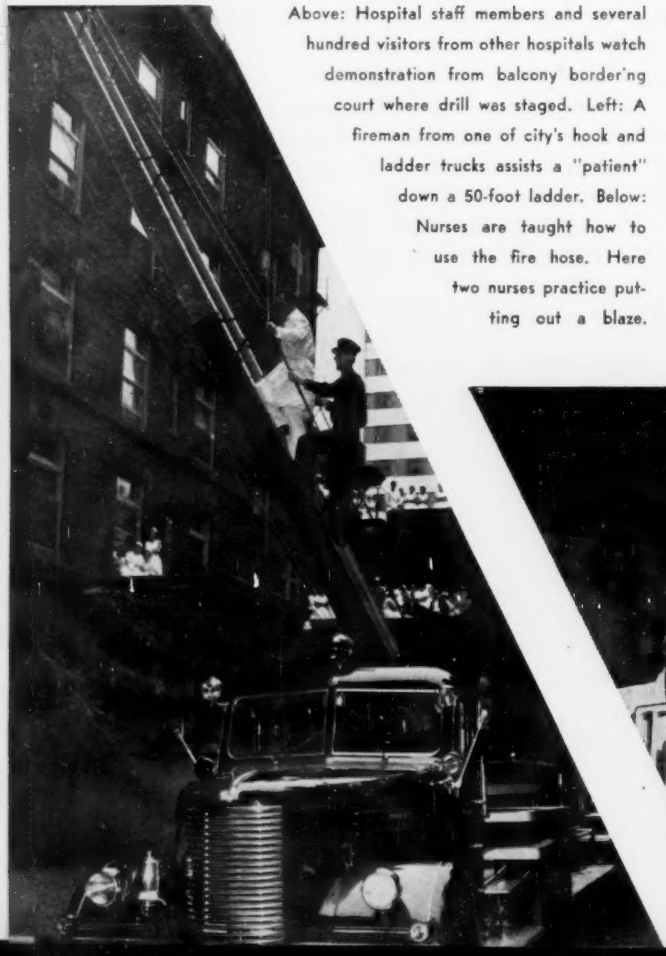
* Choy, D. S. J.: Clinical trials of a new plastic dressing for burns and surgical wounds. A.M.A. Arch. Surg. 68:33-43 (Jan.) 1954

Simulated Blaze at Presbyterian Teaches



Hospital Fire Prevention



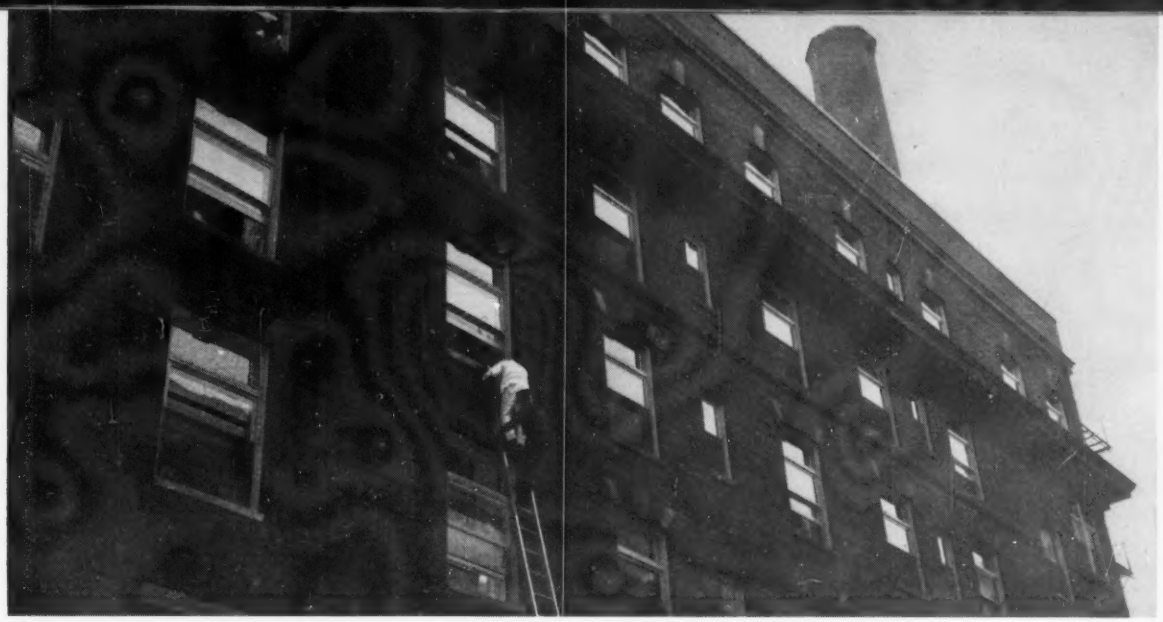
Above: Hospital staff members and several hundred visitors from other hospitals watch demonstration from balcony bordering court where drill was staged. Left: A fireman from one of city's hook and ladder trucks assists a "patient" down a 50-foot ladder. Below: Nurses are taught how to use the fire hose. Here two nurses practice putting out a blaze.

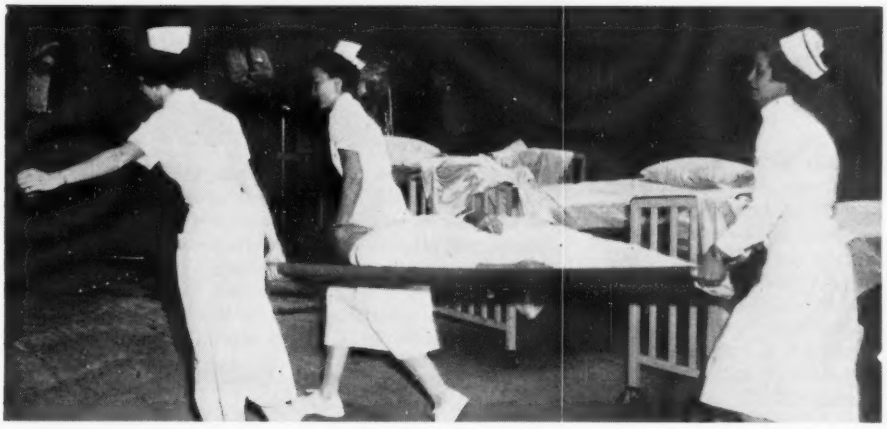
QUICK ACTION and smooth-functioning emergency teamwork was demonstrated by nurses from Chicago's Presbyterian Hospital in a special fire drill put on in observation of Fire Prevention Week.

In a series of six mock fires, staged in the hospital's court, 12 nurses demonstrated emergency technics of rescue and fire-fighting, including a number of "fireman carries" used to bring patients out of danger in different circumstances. Three doctors and six nonprofessional employees also took part in the program.

Firemen from one of the city's hook and ladder trucks demonstrated the use of a fire net and ladder rescues of patients from top story windows.

The demonstration was staged under the joint direction of



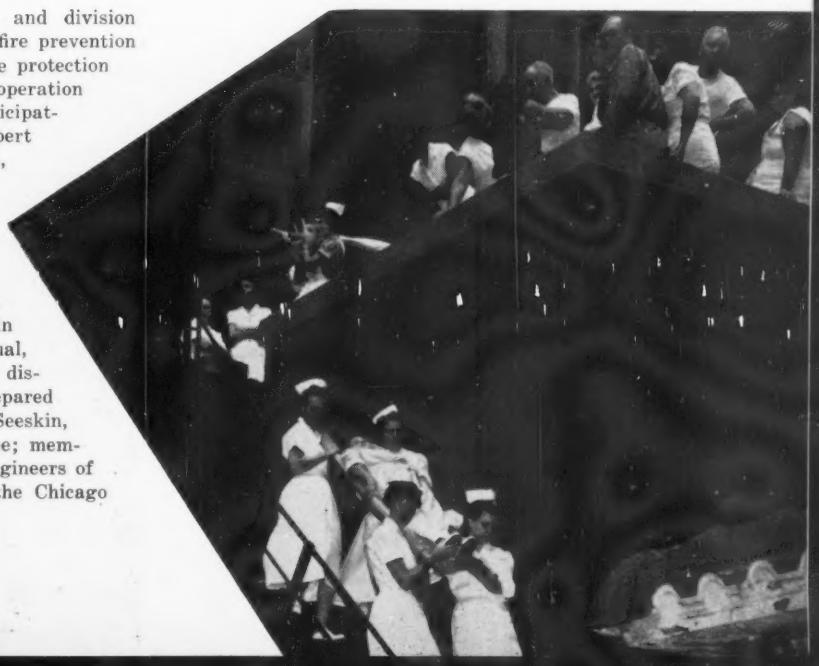


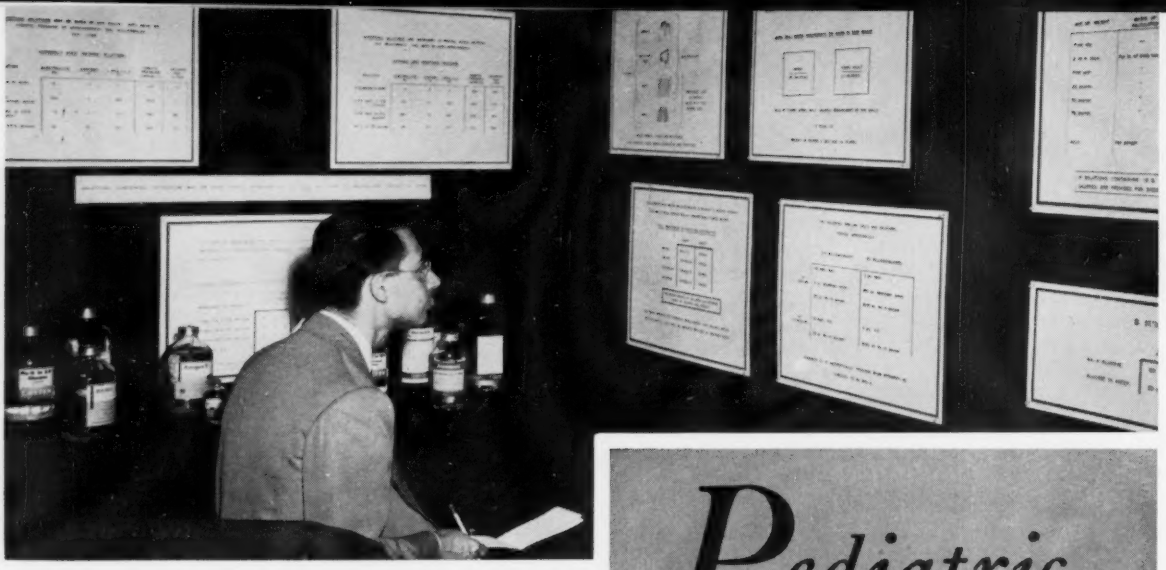
Above: A fireman demonstrates a ladder rescue from an upper story window.

Left: Speedy teamwork in bringing a stretcher patient out of danger is executed by three nurses.

Below: A swift and orderly procession of four-nurse teams carries "patients" down fire escape.

Karl S. Klicka, M.D., hospital director, and division marshal James Collins, head of Chicago's fire prevention bureau. It was a part of the hospital's fire protection program worked out by Dr. Klicka in cooperation with Chicago's fire department. The 12 participating nurses were a nucleus trained by Lt. Robert McGrath, of the city's fire prevention bureau, to teach emergency technics to other Presbyterian personnel and perhaps personnel in other Chicago hospitals. A vital part of the fire protection program is the guide manual which contains specific instructions to every person in the hospital, and the method of procedure to be followed in each department in case of fire. This manual, entitled, "Fire Protection and Control," is distributed to all hospital personnel. It was prepared by Dr. Klicka in collaboration with Philip Seeskin, chairman of the hospital's safety committee; members of the safety committee; the safety engineers of Marsh and McLennon, Inc., Chicago, and the Chicago Fire Prevention Bureau.





American Academy of Pediatrics Meets

Pediatric Nursing

● *From the 23rd annual meeting of the American Academy of Pediatrics, HOSPITAL TOPICS brings abstracts of some of the many significant papers.*

Autoclaving May Endanger Nutritional Value of Food Milk

Paul Gyorgy, M.D., Chief, Department of Pediatrics, Hospital of the University of Pennsylvania and Philadelphia General Hospital—There should be an intensive investigation of the effect of autoclaving and of any other form of preservation on the biological and nutritional value of food products. In milk and perhaps in other natural products as well, autoclaving may cause severe deterioration.

We are concerned in our present studies with the nutritional significance and value of human milk for the human infant. In cooperation with a number of associates, we were able to establish the presence in human milk of hitherto unrecognized nitrogen-containing carbohydrates which exert a powerful growth-promoting effect on a special strain of *Lactobacillus bifidus* called the Penn variant. In contrast, the comparable activity of cow's milk is only about one-fortieth that of human milk.

We showed that human colostrum, human milk, meconium, and gastric mucin are especially rich in this microbiological growth factor. In the form of gastric mucin, this Bifidus factor prevents fatty infiltration and cirrhosis of the liver in rats fed diets low in protein and choline.

Purified fractions of the factor have demonstrable antiviral activity on influenza and mumps viruses. It is too early, however, to draw any definite conclusions from our findings.

Adrenal Insufficiency Found In Rheumatic Fever Victims

Vincent C. Kelley, M.D., Ph.D., Department of Pediatrics, University of Utah College of Medicine, Salt Lake City—We have found definite evidences of abnormal pituitary adrenal cortical function in rheumatic fever, a disease ordinarily considered to be "non-endocrine" in nature.

Except during the initial phase of the disease, rheumatic fever patients have low 17-hydroxycorticosteroid concentrations, while simultaneously their blood ACTH concentrations are elevated. Since patients can increase their steroid concentrations in response to stimulation by exogenous ACTH and also during the acute phase of the disease, by response to endogenous ACTH stimulation, the adrenal insufficiency is relative rather than absolute.

Our results justify further study. Clear-cut demonstration of relative adrenal insufficiency in rheumatic fever patients provides the first definitive rationale for therapy in this disease. Since these patients have adrenal insufficiency, there is a clear indication for cortisone therapy, and since the insufficiency is relative, there is equally good rationale for ACTH therapy.

Surgery Compared with Closed Reduction In Cases of Intussusception

George B. Packard, M.D., Department of Surgery, Denver (Colo.) Children's Hospital—We studied cases of intussusception in two 10-year periods at Denver Children's Hospital, to compare the merits of closed or enema reduction with surgical treatment.

Picture at top of page: Percy S. Schaffer, M.D., Sinai Hospital, Baltimore, takes detailed notes on scientific exhibits. Dr. Schaffer was interested in "Parenteral Fluid Therapy of Children." Below: Joseph B. Miller, M.D. (r.), Mobile (Ala.) Infirmary, shows nebulizer to John Paul Burgess, M.D., Moline (Ill.) Public Hospital, at scientific exhibit on administration of Alevaire. Dr. Miller was first physician to use Alevaire in infants.

In the first 10-year period (July 1, 1934-July 1, 1944), there were 35 cases, in which there was an over-all mortality of 17.1 percent. Four patients died after surgery; two died without definitive treatment. Only a few barium enemas were used, primarily for diagnosis.

During the second 10-year period (July 1, 1944-July 1, 1954), there were only three deaths in 89 cases, making the over-all mortality 3.3 percent. All deaths were in untreated cases. Barium enemas were tried first in 39 cases, and reduction was accomplished in 20 of the 39. The other 19 had to have surgery, but in three of them the intussusception was already reduced and in three others it was almost reduced.

Advocates of preliminary barium enema point out that a high proportion of ileocecal intussusceptions can be reduced without operation; that operation has a higher mortality and a higher morbidity than the enema, and that use of the enema can save the patient the considerable expense of surgery and postoperative stay.

Advocates of initial surgery say that reduction is uncertain, and time is wasted in the x-ray room and during observation afterwards; that the enema fails to reduce the ileo-ileal type of intussusception, which makes up 15 percent or more of cases; that the doctor is unable to determine the cause of intussusception, and that there is the danger that a gangrenous bowel may be reduced or an unrecognized perforation occur.

Our series gives support to proponents of initial surgery. Operation settles finally the question of complete reduction, and it can be done with minimal risk.

Congenital Obstruction Offers Challenge To Doctors of Coming Generation

Thomas H. Lanman, M.D., Boston Children's Hospital—An anomaly which presents a great challenge to the coming generation is congenital obstruction, particularly of the duodenum. In 1950 we reviewed our results in the surgical treatment of congenital atresia of the duodenum and found that the operative mortality rate was gratifyingly low. But of those who had survived five years or more, close to 30 percent were mongols. Our series was not large—31 cases—but similar results have since been obtained at the Great Ormond Street Hospital for Sick Children in London, which has reported a slightly higher percentage incidence of mongolism in their surviving cases.

If 30 percent of the survivors of brilliant surgery done in the neonatal period for anomaly turn out to be mongols, the result can hardly be termed socially, psychologically, or economically brilliant for the family or for the patient.

Study Cardiac Malformations and Murmurs In First Year of Life

Mary R. Richards, M.D., Babies Hospital, Presbyterian Medical Center, College of Physicians and Surgeons, Columbia University, New York City—At the Columbia-Presbyterian Medical Center, under the direction of Dr. Katherine Merritt, we studied 5,964 pregnancies (resulting in 6,053 babies) over a period of five years, to get information on the incidence of heart malformations and heart murmurs during the first year of life. Figures heretofore available have been based either upon mass examinations of older children or upon autopsy data.

We gave each infant a careful physical examination during the first week of life, took x-rays of the skull and chest, and performed follow-up physical examinations at six and 12 months of age.

Fifty infants had one or more malformations of the heart or great vessels. The incidence rate (0.83 percent) is too low, for several reasons. Malformations were probably missed in the group weighing less than 500 grams at birth, and cardiac anomalies undoubtedly were missed because the follow-up study extended only to the age of one year.

New "Penn 600" incubator is demonstrated here by Robert Carlson, American Sterilizer Co., to (l. to r.) M. J. Markell, Markell Shoe Co.; Edward Sell, American Sterilizer; and Jack Schnee and Evan Katz, students at Chicago Medical School. The drawer is removable, and an explosion-proof unit can be inserted. Either Trendelenberg or reverse can be achieved from outside. IV tubing does not have to be removed when the incubator is opened. Temperature inside never exceeds 103°.

Routine chest x-rays proved disappointing as a screening procedure for cardiac malformations. Of 35 infants whose malformations directly affected the heart, in only five, or 14 percent, was a cardiac anomaly suspected on the basis of x-rays in the first week of life, but 45 infants with presumably normal hearts were suspected of congenital malformations on the basis of x-rays. A physical examination in the first week of life is a better but still inadequate lead to the discovery of congenital heart disease.

Prematurity tends to be associated with higher incidence of cardiac malformations, but this apparently is not the case with heart murmurs. Infants weighing over 3,000 grams at birth had a distinctly higher incidence of murmurs in the first week of life than did those weighing between 2,500 and 3,000 grams.

(*Continued on next page*)

At exhibit on "Angiocardiography in Normal and Abnormal Hearts," H. G. Bucheleres, M.D. (l.) and Gershon Hait, M.D. (r.), department of pediatric cardiology, Cook County Hospital, answer questions of Manonmani Gounder, M.D., and Frieda Weiner, M.D., both of Bobs Roberts Hospital, University of Chicago.

Top left: Robert E. Cooke, M.D., center, associate professor of pediatrics and physiology, Yale University School of Medicine, receives the Mead Johnson first award; and Vincent Charles Kelley, M.D., (r.) associate professor of pediatrics, University of Utah College of Medicine, the Mead Johnson second award. Roger L. J. Kennedy, M.D., (l.), retiring president of the academy, makes the presentations. The awards are given annually for outstanding original research work. The first award carries an honorarium of $1,000, the second award, $500.

Center left: Crawford Bost, M.D. (l.), San Francisco, newly installed president of the academy, congratulates Harry Bakwin, M.D., New York, on his election as vice president.

Bottom left: Thomas Hinckley Lanman, M.D. (r.), senior surgeon, the Boston Children's Hospital, and clinical professor of surgery, Harvard Medical School, receives the William E. Ladd award from Dr. Kennedy for major contribution to pediatric surgery.

Top right: Paul Gyorgy, M.D. (r.), professor of nutrition in pediatrics, and chief of pediatrics, Hospital of the University of Pennsylvania, Philadelphia, receives Borden award medal from Dr. Kennedy. The Borden award, which also includes a $1,000 honorarium, is presented annually at academy meetings by the Borden Co., for outstanding original studies and contributions to pediatrics.

Bottom right: Hugh McCulloch, M.D. (r.), recently retired editor of "Pediatrics," official journal of the American Academy of Pediatrics, receives the Grulee award for meritorious service to the academy. The award is named for Clifford G. Grulee, M.D. (l.), Evanston, honorary lifetime president of the academy and former executive secretary.

We found that seven percent of all full-term infants had murmurs at birth or at six or 12 months; and that of these murmurs, seven percent were finally interpreted as organic murmurs associated with congenital malformations of the heart or great vessels.

In our experience, when a murmur is heard at birth, chances are 1 in 12 that the child has congenital heart disease. If the murmur is heard again at six months, chances increase to 1 in 3, and if the murmur persists to 12 months, probably congenital heart disease is present in three out of five cases.

When a murmur appearing at six months persists until 12 months, the odds in favor of congenital heart disease are 1 in 7. When a murmur is first heard at 12 months, the probability of congenital heart disease is 1 in 50.

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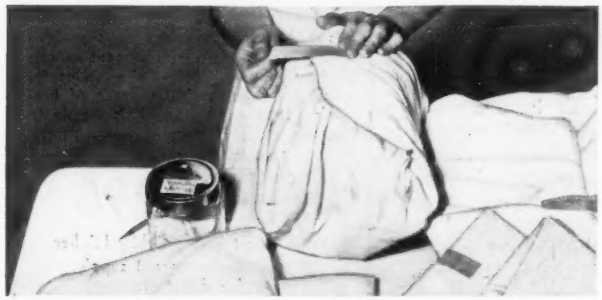

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3M COMPANY

TRADE TOPICS...

Pfaelzer Appoints New Dietetic Consultant

Ruth M. Kahn has been appointed dietetic consultant for Pfaelzer Brothers, Inc., supplier of portion control meats to the institutional field.

Miss Kahn formerly served as director of dietetics, Michael Reese Hospital, Chicago. Prior to that she was chief dietitian at Hines (Ill.) VA Hospital.

Merck Appoints McLean To New Post

William H. McLean has been appointed vice-president and general manager of the Chemical Division, Merck & Co., Inc.

He formerly was the company's vice-president for marketing.

Freund Becomes Sales Manager

William J. Freund has been named sales manager of the new Electri-Car Division, Victor Adding Machine Co. He formerly served as director of advertising, Nesco, Inc., Milwaukee. He will make his headquarters at Victor's main office in Chicago.

Economics Lab Opens New Office, Plant

Expansion plans recently announced by Economics Laboratory, Inc., St. Paul, Minn., include the opening of new executive offices in New York City, and a new plant in St. Paul.

The New York office will be headquarters for the company's sales, marketing, and advertising activities.

The new plant, the company's fourth, will manufacture mechanical dispensing equipment used in connection with Economics' detergent products.

Lever Brothers Announces Three New Appointments

Alfred A. Michaud has been appointed industrial detergents sales manager for Lever Brothers Co. Mr. Michaud was formerly central district sales manager for the industrial detergents department in Chicago.

He succeeds W. P. Black who has been appointed to the sales staff of the company's Lever division.

J. Kenneth Haher, who joined Lever Brothers' sales staff in 1953, has been appointed to fill Mr. Michaud's former position.

Saunders Appoints Rowan Managing Editor

R. B. Rowan, formerly advertising director of the W. B. Saunders Company, publishers, has become managing editor for that company.

George Brauckman, who has served in the company's production and trade departments, has succeeded Mr. Rowan as advertising director.

Pay Tribute to Upjohn Head Librarian

Miss Alberta L. Brown, head librarian, The Upjohn Company, was honored at the seventh anniversary dinner of the Pharmaceutical Section of the Special Libraries Association at its annual convention in Cincinnati recently. Tributes to Miss Brown, as founder of the section, were given by members of the pharmaceutical industry.

She was presented with a deluxe edition of the pharmaceutical section issue of Special Libraries Bulletin, devoted to the achievements and accomplishments of the section under her direction and guidance.

Miss Brown was also honored as retiring chairman of the Science-Technology Division of the Special Libraries Association during 1953-1954.

Named Sales Director For Colson Corp.

Edward C. Hamm has been named vice-president and director of sales of The Colson Corp., Elyria, O.

Mr. Hamm formerly was president and general manager of the Service Caster & Truck Corp. of Albion, Mich. and Somerville, Mass. Assets of that company were acquired by Colson last May.

Lanman to Direct Clinical Research at Schenley

B. Marr Lanman, M.D., has been appointed head of clinical research for Schenley Laboratories, Inc.

In his new capacity, Dr. Lanman will be responsible for the initiation and supervision of all clinical investigations for the pharmaceutical company.

Before joining the Schenley organization in 1952, Dr. Lanman was resident in thoracic surgery at Presbyterian Hospital, New York City.

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CAROLINE A. STILLMAN

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SANIT-ALL PRODUCTS CORP.
Greenwich, Ohio

Here is your own convention . . . .

THE DATE — *January 24-27, 1955*

THE PLACE — *Hotel Jefferson*
St. Louis, Mo.

THE OCCASION — *Second National Conference*

ASSOCIATION OF OPERATING ROOM NURSES

All operating room nurses are invited, whether or not they are members of the A.O.R.N.

NATIONAL CONFERENCE PLANNING COMMITTEE

Edith Dee Hall, R.N., chairman

Mrs. Anne Sasse, R.N., treasurer

PROGRAM ON FOLLOWING PAGES

Second National Conference

ASSOCIATION OF OPERATING ROOM NURSES

All sessions in the Gold Room, Hotel Jefferson, St. Louis, Mo.

January 24-27, 1955

MONDAY, JANUARY 24

Morning Session

9:00 a.m. — **Registration**

9:00-11:00 — **Draping Patients in the Operating Room**
Demonstration by team of St. Louis operating room nurses

11:00 — **Opening of Scientific and Technical Exhibits**

Afternoon Session

1:30 p.m. — **Opening Session**
Presiding: Mrs. Doris Walk, R.N., O.R.S., St. Louis City Hospital and local program chairman for conference
Call to order: Edith Dee Hall, R.N., New York City, Chairman, National Conference Planning Committee
Introduction of Jayne Krause, R.N., President, A.O.R.N. of St. Louis

1:45- 2:00 — **Opening Address: Cooperation Between the Surgeon and the O. R. Nurse**
by Walter E. Hennerick, M.D., Commissioner of Hospitals, St. Louis

2:00- 3:15 — **Planning the Operating Room for Efficiency**
by Frederick E. Markus, Markus and Nocka, Architects and Engineers, Boston

3:15- 3:45 — **Viewing of Scientific and Technical Exhibits**

3:45- 5:00 — **Work Simplification in the Operating Room**
by Frederick E. Markus, Boston

5:00- 6:00 — **Viewing of Scientific and Technical Exhibits**

TUESDAY, JANUARY 25

Morning Session

Presiding: Jayne Krause, R.N., St. Louis

8:45- 9:20 a.m. — **Development and Function of a Surgical Committee and Its Value to the Operating Room Nurse**
by John P. Garrison, Assistant Superintendent, Highland-Alameda County Hospital, Oakland, Calif.

9:20- 9:50 — **Role Playing by Members of the Advisory Council, New York Association of Operating Room Nurses**
(1) Surgical Committee Functioning Poorly (2) Surgical Committee Functioning Well

9:50-10:00 — **Questions from the Floor**

10:00-11:00 — **Preoperative Skin Preparation**
by Carl W. Walter, M.D., Surgeon, Peter Bent Brigham Hospital, Boston

11:00 — **Viewing of Scientific and Technical Exhibits**

Afternoon Session

Presiding: Jayne Krause, R.N., St. Louis

1:30- 1:45 p.m. — **Speaker to be announced**

1:45- 4:00 — **Panel Discussion: New Trends in Surgery**
Moderator: William Sinkler, M.D., Medical Director, Homer G. Phillips Hospital, St. Louis
Participants:
PEDIATRIC SURGERY—Robert Elman, M.D., Professor of Clinical Surgery, Washington University School of Medicine, St. Louis
NEURO-SURGERY—Edmond Smolik, M.D., Associate Professor of Neurological Surgery, St. Louis University School of Medicine
THORACIC SURGERY—C. Rollins Hanlon, M.D., Professor of Surgery, and James Mudd, M.D., Associate Professor of Surgery, both of St. Louis University School of Medicine
GYNECOLOGIC SURGERY—Alfred Sherman, M.D., Assistant Professor of Obstetrics and Gynecology, Washington University School of Medicine, St. Louis
OPHTHALMIC SURGERY—Hayward Post, M.D., former Professor of Ophthalmology, Washington University School of Medicine
Questions and answers

4:00- 6:00 — **Viewing of Scientific and Technical Exhibits**

WEDNESDAY, JANUARY 26

Morning Session

Presiding: Mabel Northcross, R.N., O.R.S., Homer G. Phillips Hospital, St. Louis

8:45- 9:30 a.m. **Planning and Management of the Recovery Room**
by Elliott Hurwitt, M.D., Medical Director, Montefiore Hospital, New York City

9:30-11:00 **Panel Discussion: Staffing the Operating Room**
FUNCTIONS OF THE R.N.—Speaker to be announced
FUNCTIONS OF THE NON-PROFESSIONAL WORKER—Speaker to be announced
FUNCTIONS OF THE STUDENT—Sister Mary Suzanne, Dean, St. Louis University School of Nursing

11:00 **Viewing of Scientific and Technical Exhibits**

Afternoon Session

Presiding: Mabel Northcross, R.N., O.R.S., Homer G. Phillips Hospital, St. Louis

1:30- 3:30 p.m. **Forum on Sterilization of Supplies**
Moderator: Mrs. Verna Wilson, R.N., O.R.S., on leave of absence, Barnes Hospital, St. Louis
Participants:
STERILIZATION BY SATURATED STEAM—P. L. Engler, Scanlon Morris Division, Ohio Chemical & Surgical Equipment Co., Madison, Wis.
STERILIZATION BY DRY HEAT—Speaker to be announced
STERILIZATION BY CHEMICALS—Velma L. Chandler, Ph.D., Chief, Department of Microbiology, Ethicon, Inc., New Brunswick, N. J.
OVEN STERILIZATION—Helen Horvat, B.S., R.N., C.S. Supervisor, John Cochran VA Hospital, St. Louis

3:30- 4:15 **Viewing of Scientific and Technical Exhibits**

4:15- 4:45 **Effective Interdepartmental Communication in the Hospital**
by Edna Peterson, R.N., President, District Three, Missouri State Nurses Association, and Director of Nurses, Jewish Hospital, St. Louis

4:45- 6:00 **Viewing of Scientific and Technical Exhibits**

THURSDAY, JANUARY 27

Morning Session

8:30- 9:30 a.m. **Viewing of Scientific and Technical Exhibits**

9:30-11:30 **Problem Clinic***
Presiding: Mrs. Doris Walk, R.N., St. Louis
Moderator: Elliott Hurwitt, M.D., New York City
Participants:
SURGEON—Cyril Costello, M.D., Medical Director, City Hospital, St. Louis
ANESTHESIOLOGIST—Seymour Brown, M.D., Chief, Department of Anesthesia, St. John's Hospital, St. Louis
ADMINISTRATOR—William Andrews, Administrator, The Peoples Hospital, St. Louis
DIRECTOR OF NURSES—Anne Campbell, R.N., Director of Nurses, Barnes Hospital, St. Louis
O. R. SUPERVISORS—Frances Reeser, Operating Room Supervisor, Bronx (New York) VA Hospital, representing government hospitals. Speaker representing civilian hospitals to be announced
O. R. INSTRUCTOR—Speaker to be announced
**Bring your problems to this clinic. Direct questions to any panel member*

11:00-11:10 **Closing of Sessions**
Edith Dee Hall, R.N., New York City

11:30- 1:00 **Viewing of Scientific and Technical Exhibits**

HOSPITAL TOURS

Barnes Hospital and City Hospital—Monday, 9:00 a.m.
Homer G. Phillips Hospital and John Cochran VA Hospital—Thursday, 1:00 p.m.

PLANT TOURS

A. S. Aloe Co. manufacturing plant—Monday morning
Seamless Rubber Co. manufacturing plant—Monday morning and Tuesday evening
The Shampaine Co.—Thursday, 1:00 p.m.

Carefully selected scientific exhibits will supplement the conference program
Informative films from many exhibitors will be shown
Complete program of surgical films to be announced

Local Committee Chairmen

PROGRAM—Mrs. Doris H. Walk, R.N., St. Louis City Hospital
ENTERTAINMENT—Mary Taylor, R.N., Jewish Hospital
SCIENTIFIC EXHIBITS—Helen Wellman, Deaconess Hospital
HOSPITALITY AND HOSPITAL TOURS—Ruth Paul Katz, R.N., John Cochran VA Hospital

Hotel Jefferson

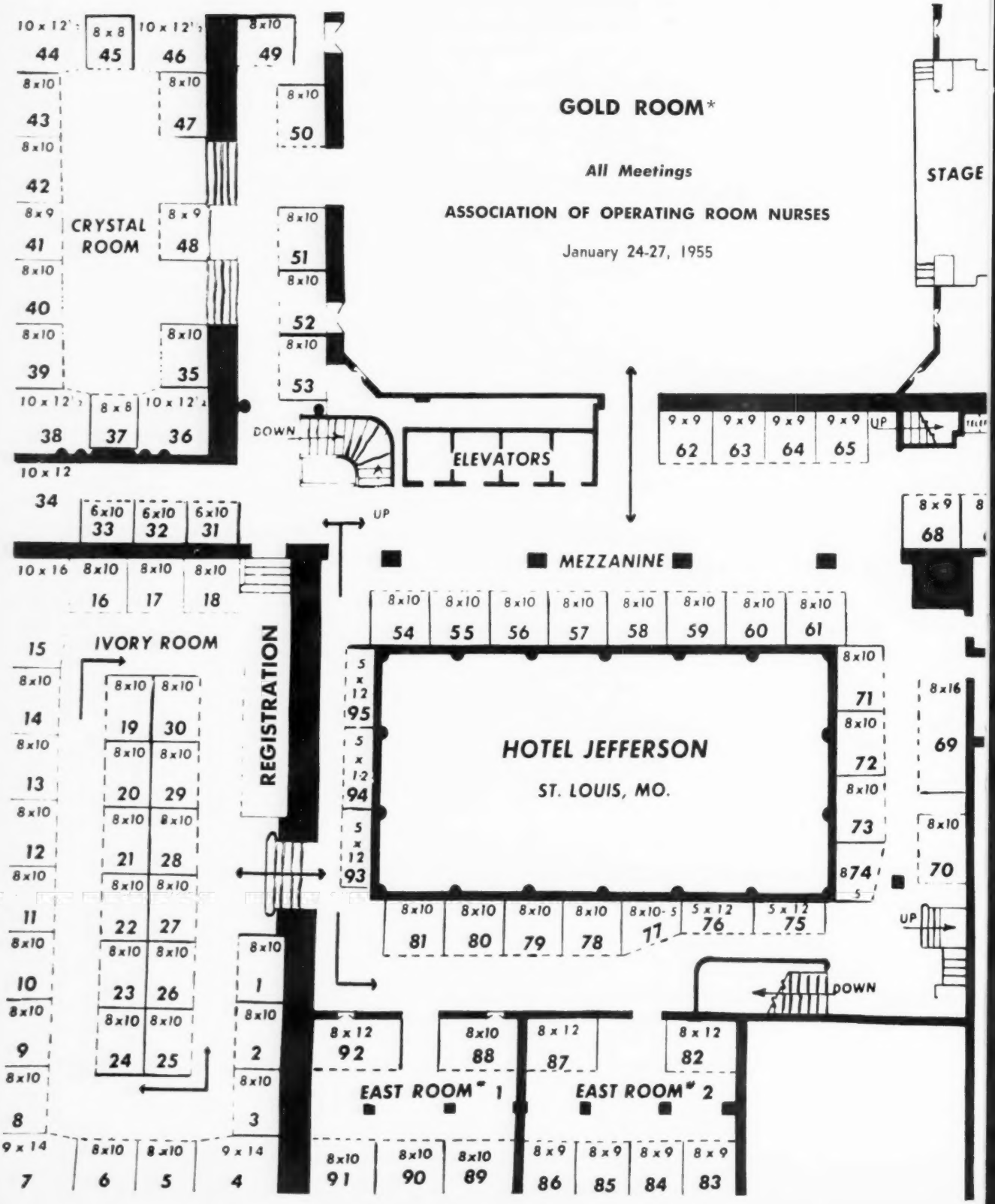
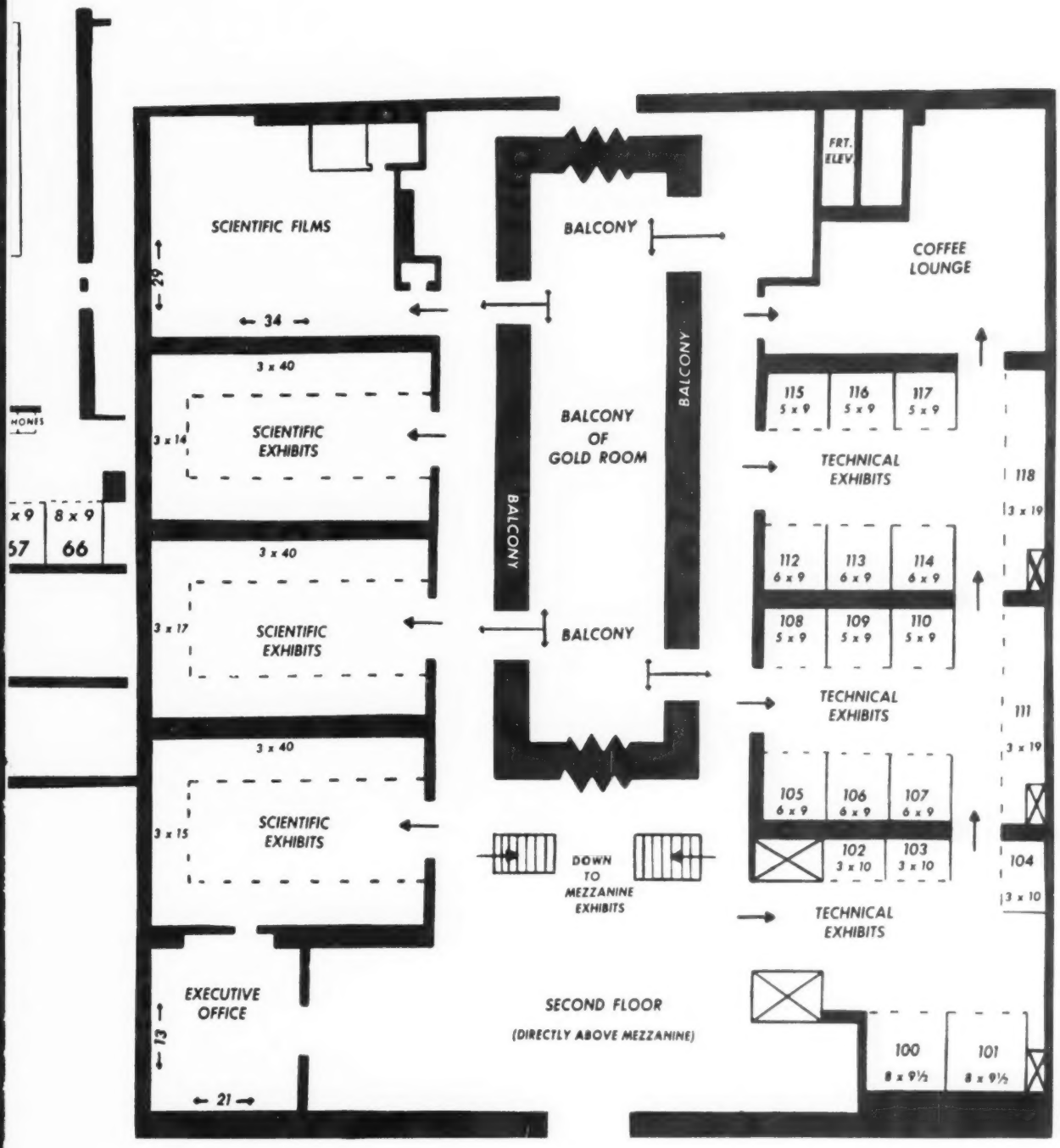


Exhibit Area



**Draping will be done in the Gold Room*

SEE FOLLOWING PAGES FOR DETAILS OF EXHIBITS

Meet the Exhibitors

Every exhibitor will have on hand qualified men to demonstrate fully any product, apparatus, or attachment.

AEROPLAST CORPORATION, Dayton, O. Booth 110. Exhibit will display Aeroplast Liquid Surgical Dressing, the plastic dressing which is applied by spraying from a self-contained dispenser. Application to surgical and traumatic wounds, burns, abrasions, excoriation, etc., will be shown by color transparencies of clinical studies.

A. S. ALOE CO., St. Louis, Mo. Booth 54. Members and guests are invited to view display of Aloe Contour Breast Pad, Aloe Dispensacart, Aloe Unipress Bandages, new Aloe Multi-Service Storage-Sink unit, and other items. Aloe also extends an invitation to visit their show room at 1831 Olive St., seven blocks from the Jefferson Hotel.

AMERICAN CYSTOSCOPE MAKERS, INC., New York City. Booth 47. American Cystoscope Makers invite members and guests to visit their surgical display of illuminated diagnostic and surgical instruments and accessories.

AMERICAN HOSPITAL SUPPLY CORP., Evanston, Ill. Booths 67-68. Exhibit will display the complete line of Baxter intravenous solutions and accessory sets, including new electrolyte solutions; Gentran, an effective, proven plasma volume expander; and the new Plexitron blood pump.

AMERICAN SAFETY RAZOR CORP., New York City. Booth 17. Exhibit will display the latest developments in A.S.R. Surgeon's Blades as well as the finest in prepping blades. Included also will be A.S.R. Double Edge Hospital Razor Blades.

AMERICAN STERILIZER CO., Erie, Pa. Booths 29-30. Exhibit will feature American Square Sterilizer, the design with a 35-100% increase in usable sterilizer capacity as compared with its cylindrical counterparts. Also shown will be Dual-Video Twin Track surgical light for use with television. Live-model demonstrations will be given on the famous 1080 Major Surgical Table, incorporating the use of an entirely new line of neuro-surgical headrests.

AUSTENAL LABORATORIES, INC., New York City. Booth 53. Austenal will display Vitallium appliances for fracture fixation and general surgery, including the Vitallium hip, elbow, shoulder and finger prostheses, patella caps, tidbial plateaus, intramedullary bars and improved intertrochanteric appliances.

C. R. BARD, INC., Summit, N. J. Booth 56. Exhibit will be devoted to three important Bard products: the new Bardic line of plastic catheters and tubes; the McQuire urinal; and Bardex Foley catheters of all kinds.

BARD-PARKER CO., INC., Danbury, Conn. Booth 1. Featured will be B-P Rack-Pack—the new method of packaging B-P Rib-Back Surgical Blades. Saves time and labor in the O.R.; protects against costly, accidental damage to sharp edges. Also to be shown: knife handles, B-P Germicide, Chlorophenyl, sterilizing containers, transfer forceps, pipettes and the Reese Dermatome.

BAUER & BLACK, Chicago, Ill. Booth 52. Telfa Non-Adherent Strip—a revolutionary and economical improvement over gauze that keeps wounds dry without sticking—will be demonstrated. Also featured will be prepackaged dressings for surgery—Curity Radiopaque sponges precounted, pre-tied in 10's; Curity sutures, including improved Chromic catgut with controlled absorption and greater "functional strength"; and specialty needle sutures for every surgical procedure.

BECTON, DICKINSON & CO., Rutherford, N. J. Booth 71. Special needles and vinyl plastic tubing will be displayed. Also on display will be Multifit syringes, Yale Cleaner, Ace Bandages, and allied products.

WILMOT CASTLE CO., Rochester, N. Y. Booths 63-64. Exhibit will display new types of sterilizers for washing and sterilizing instruments, and special new sterilizers for sharp cutting instruments employed in delicate surgery.

CHESEBROUGH MANUFACTURING CO., New York City. Booth 50. The company, sole maker of Vaseline brand products, will feature its prepacked Vaseline Sterile Petroleum Gauze extensively used in hospitals in the O.R. and for C.S. distribution.

GILBERT HYDE CHICK CO., Oakland, Calif. Booths 60-61. The company will feature demonstrations of the DV Operating and Surgical Table and the new Davis Patient Roller for transferring patients.

CLAY-ADAMS CO., INC., New York City. Booth 57. Exhibit will feature a demonstration of the Autoclip technic for automatic wound clip application and removal. A comprehensive display of Intramedic Polyethylene Tubing and special tubing adapters will be shown.

THE COCA-COLA CO., Atlanta, Ga. Booth 44. Ice cold Coca-Cola served through the courtesy of the Coca-Cola Bottling Co. of St. Louis and The Coca-Cola Co.

DAVIS & GECK, INC., Danbury, Conn. Booth 55. Company will display a comprehensive line of sutures featuring Atraumatic® needles, Surgaloy® stainless steel sutures and Surgaloy® stainless steel mesh, Melmac® resin-plaster of Paris Bandage for stronger, thinner, lighter casts that are water and urine resistant. Also Aureomycin* Chlortetracycline Hydrochloride dressing, packing, and soluble surgical powder for local antibiotic therapy.

J. A. DEKNATEL & SONS, INC., Queens Village, Long Island, N. Y. Booth 39. Display will feature Deknatel (MTN) Minimal Needles swaged on to Deknatel surgical silk, nylon, cotton and non-boilable gut; Deknatel surgical silk in dry, sterile Readi-Cut lengths, 12 to tube, with Col-R-Tip for ease of size identification and elimination of loose ends, tangling and kinking. Available in jars or cans, sterile-packed 12 to a box. Also included will be Deknatel Name-On Beads, the original baby head identification.

DE PUY MANUFACTURING CO., INC., Warsaw, Ind. Booth 19. Many new items of interest and help to the O.R. nurse, including Economy Screw Rack, plate bending tool, small hand drill, all stainless steel master screw driver, and many others.

ETHICON SUTURE LABORATORIES, New Brunswick, N. J. Booths 80-81. Featured will be Ethicon CP gut and textile sutures; Ethicon Atraloc eyeless needle sutures; Bio-Sorb absorbable dusting powder; Gamophen antiseptic surgical soap; Tantalum gauze and other Tantalum surgical materials; the Sutpak—precut sterile surgical silk and cotton sutures; and surgical steel sutures and gauze.

THE FAULTLESS RUBBER CO., Ashland, O. Booth 6. Display will include hospital combination bottle and ice bag; catheters, rectal tubes; duodenal tubes; stomach tubes; invalid cushions; colon tubes; surgical rubber tubing; ice caps; throat bags; nursing nipples; rectal syringes; infant syringes; ear and ulcer syringes; breast pumps; crutch tips, and water bottles.

THE FENGEL CORP., New York City. Booth 37. A full line of hospital, surgical, and laboratory supplies, including stainless steel utensils; glassware; rubber goods; hypodermic syringes and needles; and thermometers will be displayed. Featured will be English non-corrosive surgical needles and Swedish stainless steel surgical instruments.

**Trademark*

FENWAL LABORATORIES, INC., Framingham, Mass. Booth 78. Displayed will be the Fenwal plastic A-C-D blood-pack for safer and more convenient collection and administration of blood from standard bottles or blood-packs; a new and unique Fenwal method of fresh blood and platelet transfusions; and plastic equipment for fresh frozen plasma for hemophilia.

GOMCO SURGICAL MANUFACTURING CORP., Buffalo, N. Y. Booth 58. Display will feature explosion proof hospital suction and suction-ether units, all approved by Underwriters' Laboratories, and a demonstration of the new 766 Thoracic pump. Also shown will be the new Micromatic Ether Regulator for controlled administration of ether vapors.

GUDEBROD BROS. SILK CO., INC., New York City. Booth 31. Exhibit will feature color coded silk and cotton sutures. Also included will be the company's line of Champion Serum-Proof Silk Sutures.

HAROLD SUPPLY CORP., New York City. Booth 16. The exhibit will present the Steriphane System, a new way of delivering sterile syringes, needles and catheters to nursing areas in completely sealed envelopes (individually packed). Also featured will be the James Automatic Syringe Washer.

HAUSTED MANUFACTURING CO., Medina, O. Booth 7. Display will include Easy Lift, the two-way sliding and tilting stretcher which requires only one attendant to transfer the heaviest patient from stretcher to bed. Also the Conver-table, the five-units-in-one wheel stretcher which can be converted in ten seconds into an emergency OB, portable examining table, emergency operating table, or wheel chair.

HOFFMANN-LA ROCHE, INC., Nutley, N. Y. Booth 79. Display will feature information on Levo-Dromoran, the new synthetic narcotic analgesic; Tensilon, the new anticurare agent; Synkayvite, for vitamin K therapy; and Prostigmin, for prevention of postoperative distention and urinary retention.

HUNTINGTON LABORATORIES, INC., Huntington, Ind. Booth 8. Exhibit will feature Germa-Medica Hexachlorophene liquid surgical soap; foot pedal operated soap dispensers; Forma-San instrument germicide; Instru-San instrument cleaner; and static conductive floor finishes.

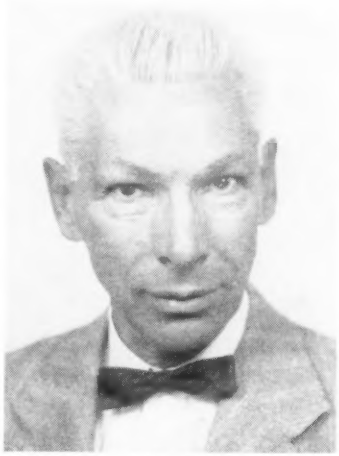
JOHNSON & JOHNSON, New Brunswick, N. J. Booth 59. Display will feature Controlled-Tension Adhesive

(Continued on last page of program)

Meet Some of the Speakers

Elliott Hurwitt, M.D.
Medical Director, Montefiore Hospital
New York City

Frances Reeser, O.R.S.
Bronx VA Hospital
New York City



Frederick E. Markus
Markus and Nocka
Architects and Engineers, Boston

Velma L. Chandler, Ph.D.
Chief, Dept. of Microbiology
Ethicon, Inc., New Brunswick, N. J.

Seymour Brown, M.D.
Chief, Dept. of Anesthesia
St. John's Hospital, St. Louis

P. L. Engler, Product Mgr.
Ohio Chemical & Surgical
Equipment Co., Madison, Wis.

PLEASE REGISTER IN ADVANCE

For advance registration, send state registration number, accompanied by $1.00 registration fee, to Mrs. Lucille Blank, Treasurer, St. Louis Association of Operating Room Nurses, 4506 Forest Park, St. Louis, Mo. Your badge and program will be ready at a special desk upon your arrival.

If registering on January 24, present your state registration card upon your arrival.

Tape. Also to be shown: the latest in Zoroc Resin-Plaster Bandages, caps, masks, x-ray detectable sponges, and a new adhesive strap.

LEHN & FINK PRODUCTS CORP., New York City. Booth 26. Among products to be featured will be new Lysol, non-toxic, non-caustic, non-corrosive, safer for nurses and patients; Lehn & Fink instrument germicide, bactericidal and fungicidal, no disagreeable odor, non-irritating.

J. B. LIPPINCOTT CO., Philadelphia, Pa. Booth 117. J. B. Lippincott, publishers of nursing textbooks, since 1878, will display volumes that have made contributions to the progress of nursing education.

MACALASTER BICKNELL PARENTERAL CORP., Cambridge, Mass. Booth 20. Exhibit will display the Fenwal System for hospital manufacture of parenteral solutions; Fenwal Pour-O-Vac and Amp-O-Vac flasking technics; MBCo Kleen-O-Matic syringe and glassware washing technic; and blood bank apparatus and serums.

MALLINCKRODT CHEMICAL WORKS, St. Louis, Mo. Booth 42. Products on display will include ether for anesthesia; plain soda lime; indicating soda lime; Urokon sodium for operative cholangiography; and chloroform for anesthesia.

MARSALES CO., INC., New York City. Booth 82. In addition to regular surgical dressing, exhibit will display a complete line of special O.R. dressings, including mastoid dressings; appendix sponges; peanut sponges; stick sponges; and tonsil sponges.

MEINECKE & CO., INC., New York City. Booth 18. Two products of interest to O.R. supervisors, which offer superior technic, convenience and economy will be displayed—Haemosol for cleaning surgical apparatus, and Sterilwraps for wrapping sterile packs.

MILLS HOSPITAL SUPPLY CO., Chicago, Ill. Booth 69. Display will include general hospital supplies and equipment; surgical instruments; operating room linens and garments; and operating room equipment and supplies.

V. MUELLER & CO., Chicago, Ill. Booth 70. Labor-saving devices for O.R. supervisors and personnel will be featured. Included will be the new Adjusta-Rak and the new Herb-Mueller Ether-Vacuum unit with recirculating oil system.

OHIO CHEMICAL & SURGICAL EQUIPMENT CO., Madison, Wisc. Booths 9-10-11. Exhibit will feature live demonstrations of the new Surg-o-ray X-P, portable explosion-proof light; the A7200 Selectrol, major operating table; and the Surg-o-beam, major operating light. Also on display will be Ohio-Scanlan's new Tenso-Pli catgut sutures; size-colored silk and cotton sutures; SterilBrite surgical furniture; and a representative line of Stille surgical instruments.

ORTHOPEDIC EQUIPMENT CO., Bourbon, Ind. Booth 62. Exhibit will display new items in the orthopedic surgery field, as well as representative samples of OEC's complete fracture equipment line.

PARKE, DAVIS & CO., Detroit, Mich. Booth 25. Medical service members of the company's staff will be on hand for consultation and discussion of various products. Important specialties, such as penicillin S-R, Benadryl, Ambodryl, Dilantin Suspension, vitamins, Oxycel, Milontin, Amphedase, and Thrombin Topical will be featured.

PELLEX, INC., New York City. Booth 43. Operating room supervisors can now take advantage of a new method of pre-operative hair removal — new clinic-tested Pellex Surgical Hair Removing Cream. Saves time, reduces risk of infection.

THE PIONEER RUBBER CO., Willard, O. Booth 21. Exhibit will feature Multi-Sized Rollprufs of latex, and of neoprene, with new rough area, plus other styles in the company's complete surgical glove line.

PROPPER MANUFACTURING CO., Long Island City, N. Y. Booth 14. Exhibit will feature Steri-Cards, OK strips, sterilizer control tubes; and demonstration of the new improved Manuell sphygmomanometer, plus the regular Propper Aneroid, mercurial and wall and desk model sphygmomanometers.

RITTER CO., INC., Rochester, N. Y. Booth 35. See complete demonstration of new Ritter Explosion-Proof Multi-Purpose Surgery Table, featuring extreme high-low positions and touch-of-the-surgeon's-toe control.

SHAMPAINE CO., St. Louis, Mo. Booth 72. Booth will be devoted to the S-1502 Major Operating Table. All controls are located at the head end and face the seated anesthetist. No dials or gear shift levers are required to place the table top in any desired position or height.

THE J. SKLAR MANUFACTURING CO., Long Island City, N. Y. Booth 4. Displayed will be Sklar's line of quality stainless steel surgical instruments. Included also will be several models of suction and pressure apparatus—approved by Underwriters' Laboratories, Inc.—for use in the presence of combustible anesthetic agents.

SMITH & UNDERWOOD, Royal Oak, Mich. Booth 93. A new type of sterilizer control will be presented at this convention. Diack Controls and newer Inform Controls (for 230° terminal sterilization of infant formula) will also be on display.

E. R. SQUIBB & SONS, New York City. Booth 15. "Squibb Nurses Notes," and a four minute excerpt of the Squibb Medical film, "Post Anesthesia Rooms," will be featured.

VESTAL INCORPORATED, St. Louis, Mo. Booth 41. Exhibit will feature Septisol antiseptic and surgical soap used for the preoperative prep of patients and as a surgical scrub for surgeons and nurses.

EDWARD WECK & CO., INC., Brooklyn, N. Y. Booths 94-95. Display will feature a completely new set of infant surgical instruments together with many new general surgical instruments. Included will be the new Loré suction tubing clamp, and new suture and wire cutting scissors.

WINTHROP-STEARNS, INC., New York City. Booth 51. Display will feature: Phisohex—the soap-free, sudsing, antibacterial detergent for shorter, more effective degerming of nurse and patient; and Zephiran—powerful, nonirritating skin antiseptic.

ZIMMER MANUFACTURING CO., Warsaw, Ind. Booth 66. Exhibit will display the company's latest models of orthopedic instruments and appliances, including the Robbins Automatic Tourniquet, a number of bone saws for surgery, and other instruments.

Other Exhibitors

Acme Cotton Products Co., Inc.
New York, N. Y., Booth 2

Aseptic Thermo Indicator Co.
North Hollywood, Calif., Booth 88

S. Blickman, Inc.
Weehawken, N. J., Booths 27-28

John Bunn Corp.
Buffalo, N. Y., Booth 23

Coles Corp.,
Philadelphia, Penna., Booth 22

Davol Rubber Co.
Providence, R.I., Booth 12

The Lawton Co.
New York City, Booth 24

Physician's & Hospital Supply Co.
Minneapolis, Minn., Booth 5

Pratt Hospital Eqpt. Co.
Los Angeles, Calif., Booth 40

E. M. Rauh & Co., Inc.
Buffalo, N. Y., Booth 74

Will Ross, Inc.
Milwaukee, Wis., Booth 48

Seamless Rubber Co.
New Haven, Conn., Booth 65

FLEX-STRAW®

THE ONLY FLEXIBLE DRINKING TUBE

PAPER BASED — DISPOSABLE

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FOR USE IN BOTH HOT and COLD LIQUIDS

FLEX-STRAW HOSPITAL-GRAM

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OB DEPARTMENT

Time and Step Savers Prove Effective at Jackson Memorial

The beautiful new obstetrical pavilion at Jackson Memorial Hospital, Miami, Fla., incorporates many time and step saving devices for nurses.

An examining and treatment room for doctors is situated right next to each nursery so that babies can be taken into the room for examination by pediatricians without going outside the nursery doors. The only times the nursery doors are opened are when the babies are taken out by the nurses (to the mothers for feeding, for instance).

The unit includes "demonstration rooms" for mothers, so that nurses can show them how to care for their babies before they go home. The rooms are right across the hall from the nurseries—one on the floor with the normal newborn nursery and one on the floor with the premature nursery.

Helen Sweeney, R.N., supervisor of newborn nursery, with "Stork Club" sign devised in hospital. "Clock" is used to designate meeting time for expectant mothers' classes.

Handy storage cabinet opens on either side—into hall or into nursery—eliminating much walking back and forth by nurses to get needed supplies. Mrs. Jeanne Stanley (l.), staff nurse, and Miss Sweeney show how easily supplies can be handed into nursery.

Use and Abuse of Oxytocics in Obstetrics Discussed at Surgeons' Meeting

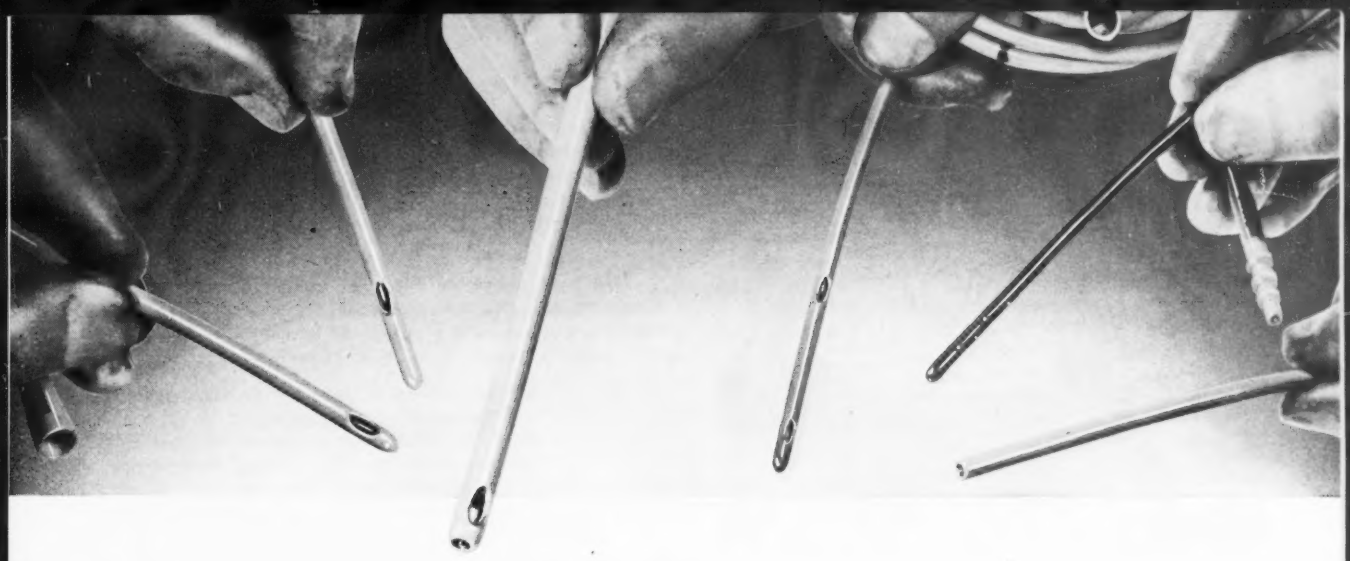
● *The following abstract is from a paper delivered at the meeting of the International College of Surgeons held recently in Chicago.*

Roy V. Boedeker, M.D., Senior Instructor, St. Louis University Medical School—This broad topic resolves itself into an outline of three main uses of oxytocics in pregnancy: (1) in post-partum hemorrhage from atony; (2) to stimulate contractions in uterine inertia; (3) in methods of inducing labor.

Post-partum atonic hemorrhage should be expected in cases of uterine hyperdistention, fibroids, and prolonged labors, in patients more than para 4 and following placenta previa, abruptio placenta, adherent placenta, or deep anesthesia. It can be avoided by never attempting the violent expression of a placenta before separation has occurred.

Ergonovine and methergine are efficient oxytocic agents for prophylactic use which present technics of analgesia and anesthesia make necessary. They are injected intravenously with the delivery of the shoulders, and since timing is important to prevent incarceration of the placenta,

(Continued on page 51)



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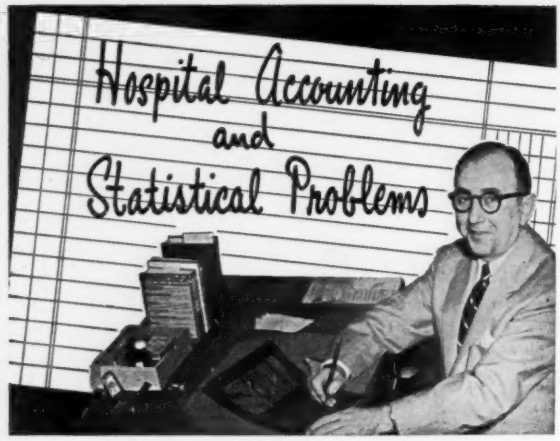

By David H. Tarlow, C.P.A.

Q. You have suggested that we deduct the sale of raw food from the cost of food in determining the cost per meal. How would this apply to meals served in the cafeteria? What about average cost per meal?

A. The problem in the cafeteria is one of fair meal count. I realize that if you were to count every unit recorded on the register, or every person served, you might obtain a distorted unit cost. You might handle the problem in one of the following ways:

(1) If you want a cost per meal served to patients only, deduct the raw food sent into the cafeteria from your computation.

(2) If you want an average cost for all meals served, divide the total receipts in the cafeteria by the raw food cost of patients' meals and use that as a unit base.

(3) Keep separate records for the cafeteria if your hospital is large enough to warrant this expense.

(4) If separate records are maintained, an apportionment of salaries and overhead expense must also be allocated to the cafeteria.

* * *

Q. We have completed a capital campaign for building expansion and find that some of the pledges have not been collected. Should this balance be shown on the hospital balance sheet? If so, in what section?

A. The balance due should be reflected on the hospital books of account by means of a completely detailed general journal entry. It would then appear in the general ledger and should be shown on your balance sheet in the plant fund section. It might be practical, however, to set up a reserve for uncollectible pledges after conference with the administrator.

* * *

Q. The administrator of our hospital has asked me to audit the bad debt write-offs for the past three years. Could you possibly set up an acceptable procedure for me to follow?

A. Our first recommendation would be that this step should be undertaken by the independent auditor. For your guidance, however, the following outline should be helpful.

(1) Prepare a work sheet schedule of all accounts written off for the period desired. With respect to each account, list the following information:

(a) Name of patient
(b) Person responsible for payment
(c) Date of discharge
(d) Date of last payment
(e) Amount written off
(f) Name of referring physician if not a service case.

Members of accountants' "52" Club held a breakfast meeting at the Palmer House, Chicago, during the recent AHA convention. Members who attended the breakfast were, front row (l. to r.): Ronald Jydstrup, AHA accounting specialist, Chicago; William Markey, Catholic Hospital Assn., St. Louis; C. Rufus Rorem, executive secretary, Hospital Council of Philadelphia; Robert Penn, Robert Penn & Co., Chicago; Lauretta Paul, director, Pontiac (Mich.) General Hospital; J. R. McGibony, M.D., professor of hospital administration, University of Pittsburgh; David Tarlow, D. H. Tarlow and Co., New York City; Sam O. Gilmer, Jr., assistant administrator, Tampa (Fla.) Municipal Hospital. Back row (l. to r.): Ray Kneifl, Catholic Hospital Association, St. Louis; G. H. Pontious, comptroller, Presbyterian Hospital, Chicago; Stuart Knox, executive director, Connecticut Hospital Assn., New Haven; Gustav Killenberg, Harris, Kerr, Forster and Co., New York City; Donald A. Bloom, comptroller, Wesley Memorial Hospital, Chicago; William Anderson, comptroller, Barnes Hospital, St. Louis; Louis Sokol, accountant, Michael Reese Hospital, Chicago; Walter Dick, partner, Hudson, McMackin and Co., Canada; Dr. Louis Block, Division of Hospital Facilities, USPHS, Washington, D. C.; Harry O. Humbert, comptroller, Johns Hopkins Hospital, Baltimore; Glenn H. Gaddis, Michael Reese Research Foundation, Chicago; S. David Kaufmann, C.P.A., Brookline, Mass.; Walter Oliver; Edwin R. Johns, comptroller, Beth Israel Hospital, Boston; Charles Roswell, McCormick, Roswell & Co., New York City.

(2) Was card or entry authorizing write-off properly signed by individual having authority to grant such allowances?

(3) If account was in hands of collection agency, was final letter sent to debtor establishing balance due as accurate?

(4) Determine cause for bad debts if possible, and learn whether any improvements can be made in credit and collection system.

* * *

Q. In preparing a supporting schedule for the security investment account, how should the details be segregated, and what should be listed with respect to each security?

A. The three broad categories would be Bonds, Preferred Stocks, and Common Stocks. With respect to each security, I would list the following data.

(1) Number of shares or bonds.

(2) Name of security fully described, i.e. first mortgage bond, 7% cumulative preferred stock, etc.

(3) Date acquired.

(4) Purchase price or value at time of acquisition if donated to hospital.

(5) Market value as at balance sheet date.

* * *

Q. Do you have any data available regarding the control of cash receipts in the cafeteria? We serve both employees and guests.

A. The type of internal control established is usually predicated upon the size of the hospital and the volume of service in the pay cafeteria. Some of the methods used are as follows:

(1) Selling meal tickets in the cashier's office.

(2) Having a clerk issue a register slip for the total charge with payment made to a cashier.

(3) Making payment directly to cashier who rings total sale on cash register.

* * *

Q. How can we properly control the receipt of postdated checks when such are accepted in settlement of a patient's account?

A. These checks when received do not constitute cash and, if accepted, should not be entered in the Cash Receipts Journal until they become negotiable. However, a receipt should be given to the payer at the time the check is received with ample explanation on the receipt that the check received becomes payable at the specific date listed. Instead of debiting a cash or bank account, the sum should be charged to a "Postdated Check" account. When the item becomes due, it should be transferred to the proper account classification by means of a journal entry. In this manner the bank account will be in proper balance and a record will be available for the possession of a postdated check.

* * *

Q. Would you please explain the difference between object of expenditure and character of expenditure? I was under the impression that the two were synonymous. In working up a budget, I was advised that these two factors had to be borne in mind.

A. *Object of expenditure* reflects the service or material thing for which expenditure is made, i.e., salaries, printing, supplies, food, etc. *Character of expenditure* refers to the distinctions between current expense, fixed expenses, and purchase of fixed assets.

* * *

Q. What is meant by turnover ratio of inventory, and how is it determined?

A. The formula for determining this information is

$$\frac{\text{Mdse. Cost of Sales}}{\text{Average Inventory}} = \text{Turnover Ratio}$$

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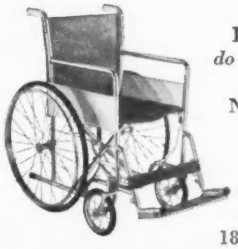

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REVIEW OF
HOSPITAL

LAW SUITS

By Leo Parker, Attorney at Law

Recently a hospital official wrote: "Some time ago in HOSPITAL TOPICS I read where an official or employee may be liable on a contract he makes for the hospital. How can an employee avoid this? If he signs his name as agent does this avoid liability on contracts?"

In view of the holdings of leading higher court decisions, the law is established that a hospital official or employee cannot by including the word "agent," "representative," etc., after his name avoid personal liability on a contract, or other instrument, which he signs for a hospital.

For illustration, in *Willis v. Watson, 26 Ala. 591*, a signature was the source of litigation, as follows:

"Benjamin Watson, Agent"

The court held Watson personally liable on the contract, and said, "The signature is merely descriptive of the person Watson himself, and does not imply that he was acting in the capacity as agent."

In still another case *(61 N. Y. S. 712)* a contract signed "John G. Porter, Agent" was the source of legal controversy. In this instance, also, the court in effect said that where a person signs a contract and uses his own name with simply the word "agent" affixed, the contract is the signer's own for which he is personally responsible. In holding Porter personally liable the court said, "He (Porter) contends that he was merely the agent of another person. . . . He signed the contract as 'John G. Porter, Agent.' The word 'agent' is mere description *personae*, and on its face the contract is that of Porter individually."

Other higher courts have held that if the hospital's name is in the body of the contract, and the employee signs the contract with the word "agent" after his name, such employee is not personally liable in the contract.

DISTINCTIONS OF LIABILITY

It is important to know that either an individual, partnership, or corporation can be equally and fully liable in damages on a contract or debt made by an employee who is properly authorized to represent and obligate his employer in the making of the specific contract. Quite obviously, the kind of testimony and evidence necessary to prove an employee was properly and legally authorized to represent an individual, is different from testimony and evidence necessary to result in a partnership or corporation being liable under the same circumstances.

While the important advantage of an ordinary partnership business is that two or more persons may unite their money, labor, services, and ability for the purpose of operating a hospital business, a real disadvantage of a partnership is that any one partner is personally liable for the total debts or obligations of the entire partnership, providing the other partners are insolvent.

Of course, if all partners are financially responsible, each partner must pay a proportional share of the assumed debts and obligations of the partnership. A silent partner is equally liable. This law is applicable to all liabilities of the partnership.

An important advantage of incorporating a hospital business is that a corporation never is liable for any act of an employee not within the scope of the employment, or for contracts not within the scope of the business as defined by the corporation's charter, and not authorized by the directors. Moreover, any person who transacts business with a corporation is bound to know that the official or employee who assumes to represent the hospital company is legally authorized to bind the corporation. Otherwise the corporation is not liable.

On the other hand, no member of a partnership may avoid liability for debts pertaining to the business, and which were contracted or authorized by any other partner.

STATE LAW PROTECTS HOSPITAL

Damage allowances can be very high to visitors and employees in a hospital. However, hospital officials must keep in mind that state compensation laws will give protection against excessive damage allowances to injured employees. In the case of *Bowers v. Peerless, 267 Pac. (2d) 556*, an employee sustained severe injuries and had a permanent disfigurement of the face. The employer had compensation insurance under state laws which specified $3,000 as the maximum he could receive.

It is interesting to observe that this higher court held that although the employee may have received a high damage allowance, yet under the compensation law he could not be awarded for his injuries more than $3,000. The fact that the hospital employer carried the insurance under the State Workmen's Compensation Law prevented the employee from sueing for damages.

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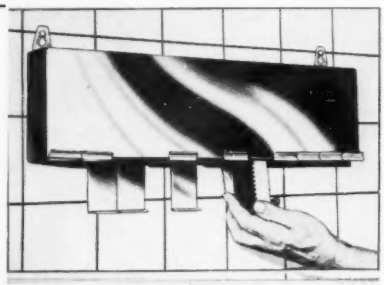

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HOSPITAL

Trends

BY LOUIS BLOCK, Dr. P. H.

Facts About Salaries

Concluded

This month Dr. Block concludes a two-part article on facts about hospital salaries. Statistics were taken from the annual Hospital Salary Survey, *published by the American Hospital Association.*

UNTRAINED WOMEN

Salary: The average gross monthly starting salary for untrained women increased from $92 in 1945 to $136 in 1953. The chances for getting a higher starting salary for this group of employees is better in the Pacific region and least in the West South Central region; is better in hospitals over 200 beds in size, in government-owned hospitals as against nonprofit and church hospitals, and in mental and tuberculosis hospitals as against general hospitals. No trends of increase or decrease were established by metropolitan area size or location of hospital.

Hours of work: The average number of scheduled hours of work per week decreased from 48 in 1945 to 44 in 1953. The chances of getting the shortest work week are in the Pacific region. Although the variations in hours of work per week was slight, the work week was shorter in the larger metropolitan areas and in tuberculosis hospitals as compared with general and mental hospitals. There was very little difference noted by size of hospital or by control group.

Vacations: The average number of days of vacation allowed after one year of work decreased from 13 days in 1945 to 12 days in 1953. Although the differential in days from place to place and area to area was slight, the chances for getting a longer vacation period was better in the New England, Middle Atlantic, West South Central and Mountain regions; in the larger hospitals, in state and municipal hospitals as compared with church hospitals, and in mental and tuberculosis hospitals as against general hospitals.

Extra pay for evening shift, night shift and split shift: The proportion of hospitals offering extra pay for evening shift, night shift and split shift amounts to 19 percent, 22 percent and 5 percent respectively during 1953. The chances for getting extra pay for these shifts were better in the larger hospitals, in larger metropolitan areas, and in general hospitals.

Overtime in cash: Almost half of the hospitals pay untrained women for overtime in cash. The chances of getting cash for overtime increased with the size of the hospital, with the size of the metropolitan area, and was better in church hospitals than in government hospitals, and in general hospitals as compared with tuberculosis or mental hospitals.

Automatic salary increases: The proportion of hospitals providing automatic salary increases was almost two hospitals in three. The chances for getting automatic salary increases increased with the size of the hospital and was more frequent in mental hospitals than in tuberculosis or general hospitals. There seemed to be no definite pattern by metropolitan area size or by type of hospital control.

Maintenance: Hospitals that provide complete maintenance for this group of personnel amounted to only 7 percent. The proportion that offered complete maintenance increased slightly with the size of the hospital.

UNTRAINED MEN

Salary: The average starting salary for untrained men increased from $107 in 1945 to $160 in 1953. The chances for getting a higher starting salary for this group of employees is better in the Pacific region than in other regions of the United States; is better in government-owned hospitals than in church, proprietary, or nonprofit hospitals, and is better in mental and tuberculosis hospitals than in general hospitals. Size of hospital or size of metropolitan area does not show any trend pattern.

Hours of work: Average hours of scheduled work per week decreased from 49 in 1945 to 42 in 1953. The chances for getting a shorter work week are better in the Pacific region than in other regions of the United States.

Vacations: The average number of days of vacation allowed after one year of employment decreased from 13 days in 1945 to 12 days in 1953.

Extra pay for evening, night and split shifts: Extra pay for evening shift was given by only one hospital in seven, for night shift by one hospital in six, and for split shift by one hospital in 24. Despite the fact that there was considerable variation by region, the chances for receiving extra pay for the different shifts was much better in the Pacific region.

Automatic salary increase: Almost two hospitals in three reported giving automatic salary increases to untrained men. The chances for receiving such automatic salary increase was best by far in the Pacific region.

Overtime paid in cash: Almost half of the hospitals reported that overtime was paid in cash. The Mountain and South Atlantic regions showed a higher proportion of hospitals doing so than did the other regions.

Uniforms: Approximately one hospital in six provided uniforms for untrained men. In the Middle Atlantic and South Atlantic regions the proportion was three hospitals in 10 as compared with one hospital in 21 in the West North Central region and one hospital in 13 in the West South Central and Mountain regions.

Maintenance: Only six percent (one hospital in 17) offered complete maintenance to untrained men. This varied from as little as one hospital in 67 in the Pacific region to as high as one hospital in 12 in the Middle Atlantic region. Better than one hospital in three (35 percent) offered no maintenance whatsoever. This ranged from a high of almost two hospitals in three in the Pacific region which did not offer maintenance to untrained men, to a low of one in seven in the South Atlantic region.

CLERKS

Salary: The average starting salary for clerks increased from $112 per month in 1945 to $166 in 1953. The chances for getting the highest average starting salary was better in the Pacific region than in other regions of the country, in the very small and in the very large hospitals, in the small rural and in the very large metropolitan areas, in government hospitals rather than in church, nonprofit or proprietary hospitals, and in tuberculosis hospitals rather than in mental or general hospitals.

Hours of work: The average number of hours of work scheduled per week for clerks decreased from 45 in 1945 to 42 in 1953. The lowest number of hours per work week

(*Continued on next page*)

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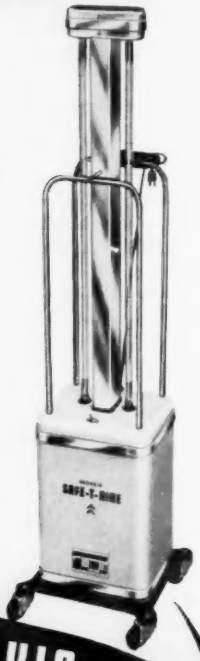

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for this group was in the Pacific region and the highest in the East South Central and West South Central regions.

Vacation: The average number of vacation days allowed after one year of employment to clerks decreased from 14 days in 1945 to 13 days in 1953. The highest number of days are still being allowed in the Middle and South Atlantic regions.

Extra pay for evening, night, and split shifts: Extra pay for evening shift was given in only 10 percent of the hospitals, for night shift in only 11 percent, and for split shift in only three percent of the hospitals. The Pacific regions show the highest proportion of hospitals offering extra pay for evening and night shifts, while the Mountain region shows the highest percentage of hospitals offering extra pay for split shifts.

Automatic salary increase: Automatic salary increases to clerks were given in almost two in three hospitals. The best chances for receiving automatic salary increases was in the Pacific region.

Overtime paid in cash: Overtime was paid in cash in 41 percent of the hospitals, the highest proportion being in the Pacific region.

Uniforms: Less than one hospital in 50 provides uniforms for their clerical personnel. This varied from as little as one in 90 hospitals in the Mountain region to one in 25 hospitals in the New England region.

Maintenance: Almost half of the hospitals do not provide maintenance of any kind to clerical personnel, while only three percent provide complete maintenance. The Pacific region provides the least proportion of complete maintenance and the highest proportion of none at all.

PRACTICAL NURSES

Salary: The average starting salary for practical nurses increased from $113 in 1945 to $169 in 1953. The chances for getting the higher starting salaries were better in the Pacific region. The chances for the higher salary also increased with increased hospital size, were better in the very small and in the very large metropolitan areas, were better in government hospitals than in church, nonprofit or proprietary hospitals, and were better in tuberculosis and mental hospitals than in general hospitals.

Hours of work: Average hours of work scheduled per week for practical nurses decreased from 49 in 1945 to 43 in 1953. The lowest work week for practical nurses was in the Pacific region.

Vacation: The average number of days of vacation allowed after one year of employment was reduced from 14 days in 1945 to 13 days in 1953. The longest vacation period was in the Middle Atlantic region, which showed no change during that period.

Extra pay for evening, night, and split shifts: Extra pay for evening shift was given in 40 percent of the hospitals; for night shift in 43 percent, and for split shift in only 7.5 percent. The New England area shows the greatest proportion of hospitals offering extra pay to practical nurses for evening and night shifts, while the Mountain region shows the greatest proportion for split shifts.

Automatic salary increases: Approximately seven hospitals in 10 provide for automatic salary increases to practical nurses. The Pacific region shows the highest proportion of such hospitals.

Overtime paid in cash: Half of the hospitals pay practical nurses in cash for overtime.

Uniforms: Less than 4 percent of the hospitals provide uniforms for their practical nurses.

Maintenance: Only one hospital in 12 (8.1 percent) provides complete maintenance for practical nurses, while almost two hospitals in five provide no maintenance to this group of employees.

The Book Corner

Paying for Medical Care In the United States

By Oscar N. Serbein, Jr. Published by Columbia University Press, New York. 543 pages.

It is highly important that the hospital administrator view changes and trends in payment for medical care. An objective view of this subject can be gained by reading this book.

The material was obtained during a study conducted under a grant from the Health Information Foundation. The object of the investigation was to determine the source of funds used in obtaining medical care. Additional aims were to evaluate the methods of payment and to utilize the findings to foresee future trends. The study was begun in 1951.

Only estimates can be made regarding the cost of illness. The guess for the year 1951 is $10,000,000,000 for medical expenditures. The amount does not represent a large fraction of the national income, yet it hits certain individuals and groups harder than others because of the unequal distribution of illness. Perhaps a little over half this amount is paid for out of current income and savings; an additional 10 percent is derived from loans. The remainder comes from business expenditures, including workmen's compensation, from governmental sources, from prepayment plans, and from philanthropic sources.

All these methods of payment are statistically reviewed and discussed in Serbein's book. The 237 tables form the basis for discussion in the text.

O.B. DEPARTMENT

(Continued from page 44)

the shoulders and trunk of the baby are delivered slowly.

Once the diagnosis of atonia is made, an intravenous infusion of 1:1000 pitocin in 5 percent dextrose in water is started and crossmatching of blood is ordered. While the uterine response is awaited, its cavity is investigated manually for retained cotyledons, and firm pressure is made over the fundus with the abdominal hand in order to anteflex the uterus over the vaginal fist in the relaxed lower segment. This and blood replacement are all that need be done.

Hazards of using any oxytocics during the first and second stages of labor still exist when these agents are indiscriminately used by unqualified personnel in poorly staffed or poorly equipped hospitals. Tragic results are inevitable if these drugs are used in a haphazard selection of patients and without proper attention during the administration.

However, the need for a safe oxytocic in prolonged labors with uterine inertia existed until 1949, when Hellmann showed that pitocin in dilute solution by careful intravenous drip obviated many of the dangers and enhanced its effectiveness.

Once the termination of pregnancy is decided upon, intravenous pitocin is a dependable method in 95 percent of cases in which there is a soft cervix with effacement and 1-2 cm. dilatation. Close regard for these prerequisites, plus amniotomy after regular contractions have started, will increase the successful induction rate to nearly 100 percent. When these prerequisites do not exist, e.g. in a primipara with long closed cervix and unengaged head, the use of any oxytocic is an abuse and such a pregnancy should be terminated by cesarean section.

Intravenous dilute pitocin is, in our opinion, the modern oxytocic, because when it is intelligently used, its action is more physiological and more readily controllable. Statistically, it is safer and more effective.

HANOVIA
LUXOR ALPINE LAMP

An invaluable aid in the treatment of psoriasis

The Goecheman technique (crude tar and ultraviolet radiation) is very helpful in many cases. Ultraviolet light produces a definite chemical change in the tar. This combination is reliable and effective.

In hospitals, in offices, the Hanovia Luxor Alpine Lamp is proving the value of ultraviolet in the treatment of many other conditions. Of proven value in internal medicine, pediatrics, obstetrics, dermatology, and orthopedics.

Among the features which distinguish the Hanovia Luxor Alpine Lamp are its instant start and its rapid build-up to full intensity. It provides intense radiation with even distribution of wide shadowless surfaces. Flexible, may be adjusted to any desired position. Low in original cost, economical to operate.

HANOVIA
AERO-KROMAYER LAMP

First air-cooled ultraviolet lamp for local and orificial application

Cooled by air instead of water, using new principles of aero-dynamics, the Hanovia Aero-Kromayer lamp provides the most minute and accurate control of any required degree of clinical actinic reaction on skin surfaces or within the body cavities. A very intense source of focused ultraviolet energy, the Hanovia Aero-Kromayer Lamp can produce a first-degree erythema in 2 seconds when in contact with the average untanned skin. May be tilted up or down sharply while lighted—operated in any position—without decreasing its ultraviolet emission. An invaluable facility for orificial work.

Ask your surgical dealer for a demonstration.

YOURS ON REQUEST: Authoritative treatises describing ultraviolet in various conditions. Write for your brochures today. No obligation.

HANOVIA
Chemical & Mfg. Co.

Dept. HT-11, Newark 5, New Jersey

BUYER'S GUIDE

952. Percolator for irrigating solution

New unit, recently introduced by American Cystoscope Makers, Inc., automatically keeps a percolator bottle filled with an irrigating solution from a storage bottle in the lower compartment of the cabinet. An electric pump inside the cabinet is switched on, to build up air pressure in the lower bottle, which forces the solution up into the percolator. When the percolator is filled, the special Weyrauch valve at the top cuts off the flow of water. The pump continues to operate until the air pressure in the lower bottle reaches 3½ to 4 pounds, at which point a pressure-sensitive switch is activated to stop the pump. As the irrigating solution flows to the patient, the solution level in the percolator lowers and the Weyrauch valve opens to admit more solution, reducing the air pressure in the lower bottle. This automatically starts the pump, to restore the pressure to its original level. For further manufacturer's information, check No. 952, Buyer's Guide card facing page 66.

953. Chalkboard shows patient's history

Furnishes history at a glance. Lists the patient, doctor, tests, medication and remarks. The porcelain enameled steel-faced board also serves as a magnetic bulletin board. Green in color for maximum readability. For further information, be sure to check the postpaid reply card facing page 66. Bettinger Corp.

954. Huge tumbler for drying clothes

J. Ross Castendyck, president, Challenge Mfg. Co., recently announced that his company has secured the manufacturing rights to the Grantham Tumbler. He considers it the most revolutionary tumbler ever introduced in the laundry industry. With the exception of loading, it operates automatically. Operator loads 200 pounds (dry weight figure) into the machine, presses a button, and the tumbler goes to work. It dries, tumbles, and automatically unloads the entire load (see illustration). Completely dries a full load in 15 minutes. For further information, check the post-paid reply card facing page 66. Challenge Mfg. Co.

955. Air purifier promises positive relief

Flick of switch, according to the Norge Division, Borg-Warner Corp., means positive relief for many of the nation's asthma and hay fever victims. The air purifier, which removes 99.4 per cent of pollen, mold spores, house dust, and other air-borne allergens from room air, can be used as window unit or table model. Rate of air circulation is regulated by dial. For additional information, check reply card facing page 66.

956. Emergency operating light, batteries

A new emergency or "disaster" light, complete with batteries and charger, has been announced by Burton Mfg. Co., Los Angeles 64, Calif. In the event of a power failure, this big No. 1785-EL 2,500-footcandle illuminator automatically switches over from line current to its own standby batteries without loss of its high intensity beam of color correct, shadowless white light. Battery capacity for over three hours of continuous service. Tilts, rotates, angles to any position. Easy rolling casters for immediate use anywhere. Manufacturer claims cost so low, hospitals can afford several.

957. Pocket case name-or-message printer

New low-priced printers for situations requiring clean, clear, instantly legible endorsements. Name, address, and phone number or other messages can be conveniently carried in purse or pocket. Extremely compact case that contains an excellent ink pad which automatically inks the printer when the case is closed. Three types of cases are available, and include plastic, leather or metal. For prices and complete information, check No. 957, facing page 66. Wellington Organization.

958. Guard needles against hepatitis

Stainless steel needle container helps guard against infectious hepatitis. Protects needle points at all times and prevents them from becoming clogged. This technic is also an efficient method for returning needles to central supply. Provides method for handling needles during processing. For prices and a suggested efficiency technic, check the post-paid reply card facing page 66. Harold Supply Corp.

959. Handy combination cutter and marker

A handy combination tool which includes a precision cutting blade to open cartons and packages of materials without damage to contents, and a standard drawing crayon for marking prices, costs, balances left in open carton, etc. Both crayon and blade are retractable. Markut Tool Co.

960. Combined hot plate-magnetic stirrer

The Lanco combined hot plate-magnetic stirrer is said to solve the difficult problem of heating liquids while stirring magnetically. Base of the compact apparatus is a light casting that houses the controls for heating and stirring, and the stirrer motor. Hot plate assembly plugs into top of base and is easily removable. A stainless steel support rod threads into the base. Rheostat control of motor permits most effective speed for each particular liquid, and an input controller allows variable heating from 0 to 400 watts. Glass-enclosed stirring magnet supplied with each unit. Arthur S. La Pine and Co.

No. 952
No. 953
No. 954
No. 955
No. 956
No. 957
No. 958
No. 959
No. 960
PATIENT
DOCTOR
OPERATION
REMARKS
YOUR NAME
STREET ADDRESS
CITY & STATE

BUYER'S GUIDE

Continued

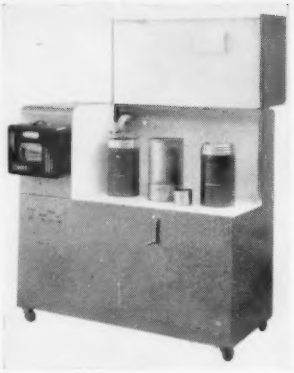
975. Prepares food in serving pans

The Cleveland Range Company's new model Steam-Chef is built to accommodate standard steaming baskets when desired. Many foods can be steam cooked in standard cafeteria pans and placed directly on serving tables without transfer of food to serving trays. Frequent small-lot cooking in cafeteria pans is fast and convenient and insures freshly-cooked foods during mealtime rushes. Helps eliminate leftovers and costly throw-out losses. Check No. 975, facing page 66, for additional information.

976. Multi-storage sink unit

Convenient to the nurse as well as space saving. Use as medicine sink, narcotics locker unit at nurses' station, dispensing sink unit in the workroom of the nursery, or as combination dressing table, sink, and storage unit. Adjustable shelves in the upper compartment, and sliding glass panel for the narcotics cabinet. Illuminated with a fluorescent lamp. For further details check the card facing page 66. A. S. Aloe Co.

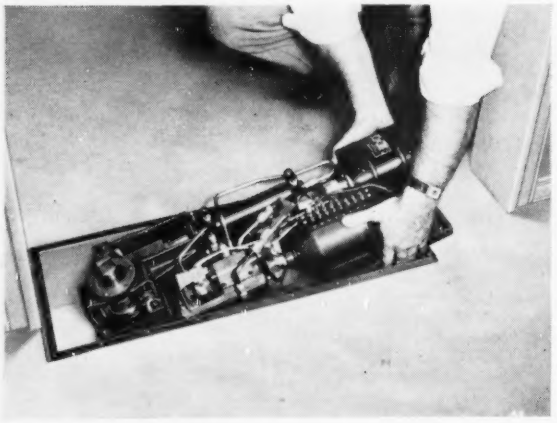
961. Histological freeze-dryer



Research into the basic structure of living tissue, such as studies of cancer and brain tumors, will be stimulated and greatly facilitated by a new histological freeze-drying unit just introduced by F. J. Stokes Machine Co. The new Stokes unit dehydrates plant or animal tissue specimens under a vacuum of 0.1 micron at a very low temperature, well below the eutectic point for biological materials. This prevents oxidation, and movement of the individual chemical components of the cells, so that they retain their original shape, form, and orientation. For other interesting details about this new product, check No. 961 on the post-paid reply card facing page 66.

994. Cotton cloth heat-sealing tapes

Thermoplastic coated cloth tapes for permanently splicing and reinforcing cloth, paper, leather and similar materials have been added to Permacel Tape Corp.'s line of industrial self-sticking tapes. Normally applied in five to ten seconds with a hot iron, the new products can withstand immersion in water and commonly used solvents, and exposure to temperatures up to 250 degrees, without materially affecting the seal. Available in white and a variety of colors.



962. Electro-hydraulic door operator

Entire mechanism is compact package 29″ long x 11″ wide x 6½″ deep. Easily installed under the door's threshhold and activated by a treadle or electric eye. Opens automatically, is quiet and safe. Besides speeding traffic flow, these door control systems are said to aid in reducing heating and air conditioning costs. This model completely eliminates compressors, piping, and the running of hydraulic lines. For additional information, check the card facing page 66. National Pneumatic Co., Inc.

Food containers being filled with hot food by cooks from a set-up of steam cooking kettles. The Aervoid containers are sealed with an air-tight cover which keeps the contents piping hot until served to patients.

Here, with the use of gas fired urns, coffee is being poured into the coffee carriers. Through this operation the coffee can be prepared in advance of the time of serving and will keep hot for hours.

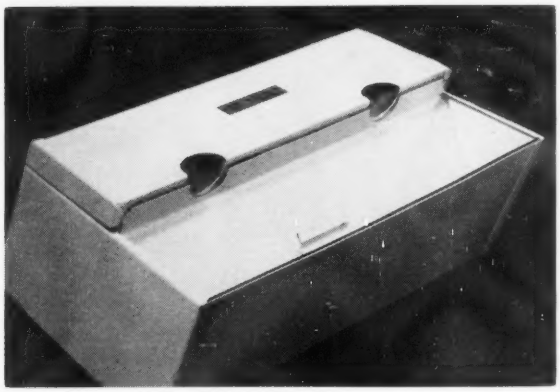
In this hospital the transportation of food to 12 dining rooms is accomplished by a battery-charged tractor that hitches onto a string of flat cars. One large vacuum can weighs about 150 lbs. when filled.

At the serving tables (illustrated above left) a rack containing these large pans fits into each vacuum container. Food can be cooked right in the pans, improving its tastiness and quality. All the equipment is stainless steel.

After usage (illustrated above right) the containers are returned to the central kitchen where they are easily cleaned, sterilized and stored away until the next meal is prepared.

963. Vacuum cans simplify mass feeding

Aervoid Hot Food Carriers, manufactured by Vacuum Can Co., are designed to simplify and reduce cost of hospital food service. The huge stainless steel containers utilize the principle of the well-known vacuum bottle. Lincoln (Nebr.) State Hospital uses the system to feed a patient population ranging from 1,650 to 2,500 (See illustrations above and left.) Patients are fed in 12 dining rooms from one central kitchen in the following manner: In the central kitchen, food is prepared, packed in the pre-heated stainless steel food containers, and transported to the dining rooms via small flat cars pulled by an electric tractor. Food arrives piping hot with no reheating to destroy much-needed food values. Dietitians can keep a closer watch on every phase of preparation and cooking since all food is prepared simultaneously at one central location. No need to time preparation to the split second, since the vacuum cans will keep food warm or cold for many hours. For more interesting facts and typical examples of how this system works in hospitals, check No. 963 on the Buyer's Guide card facing page 66.

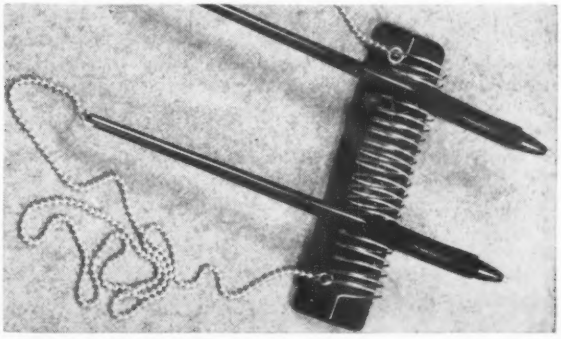


995. New film dispenser roll

A new saran film dispenser roll announced by The Dow Chemical Co. assures new ease and efficiency in hand-wrapping sandwiches, luncheon meats, cheese and baked goods. Designed to accommodate rolls 9″ through 12″ in width, other features of the dispenser include a tension spring for smooth, even feed of film; a guide to hold film in correct position; automatic spring to insure easy grasp of new sheet. Has hinged cover that lifts for easy reloading.

996. Combination pen set

To hospitals keeping day-time records in blue ink and night-time records in red, the Blue-Red pen set offers outstanding advantages. Set includes two ball point pens, one finished in black plastic with blue ink filler, the other in red plastic with red ink filler, and a handsome black lucite and brass wire self-anchoring rack holder. Twenty-four inch beaded brass chains fasten pens to rack. Long writing and non-smear, pens are said to assure perfect writing balance.



BUYER'S GUIDE

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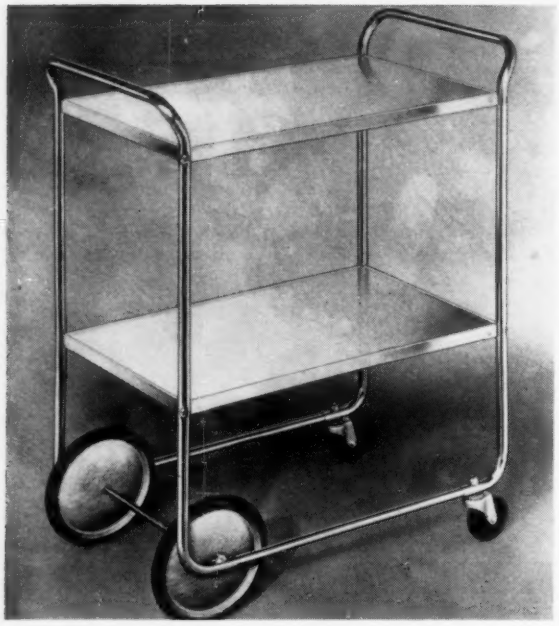
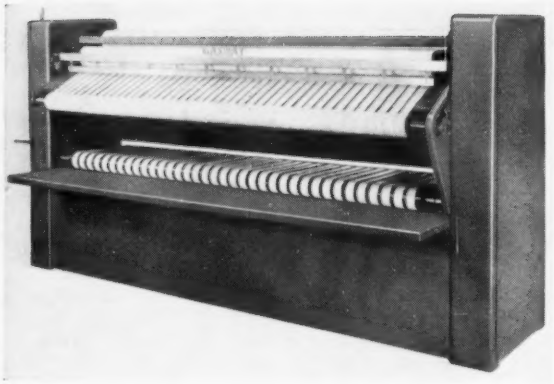


966. New low-price line utility carts

For use as medicine carts, dressing carts, laboratory carts, equipment carts, supply carts, dish carriers, and general utility use. New chrome-plated tubular steel frame, 15½ x 24 inch stainless steel shelves, raised lip on edges of all shelves, ball-bearing swivel casters with rubber wheels and two 8-inch wheels. Models are with or without the large-size wheels. For prices and further information on these carts, check the Buyer's Guide card facing page 66. Lakeside Mfg. Inc.

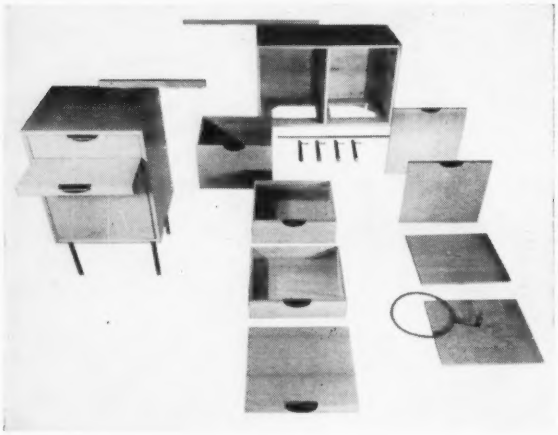
967. Aid for x-ray operators

Patients lying under x-ray machines can be tilted in either direction and at any speed on a new table designed by Keleket X-Ray Corp., a subsidiary of Tracerlab, Inc. The table lets a patient be turned head up and feet down, for instance, then be revolved to a right-side-up position at whatever speed the operator wants. Because the rate that the table moves can be controlled perfectly, better x-ray pictures will result, according to the company's executive vice president, J. L. Mueller. Some x-ray technics, he explains, require the subject's body to be moved at a slow speed, while others require a relatively fast one. This new equipment, as reported by the Wall Street Journal, is the first to offer variable speeds. For other features of this new table, check No. 967 on the reply card facing page 66.



968. Ironer features "hand-ironing" action

Gasway Corp. announces its new line of 3-D flatwork ironers. This third dimension is "hand ironing action," an ingenious method of working linens sidewise as well as lengthwise as they pass through the ironer. The action that results is said to duplicate the work of a careful hand laundress, completely eliminating running wrinkles in the work. The addition of a bank of heat-proof ribbons to carry the work from the back of the machine toward the front, in contact with the under-surface of the heated cylinder, increases usable cylinder surface to 88%. This makes possible greater ironing surface with a smaller cylinder, and results in more production capacity in less floor space. For additional details, check the card opposite page 66.



969. New line of patient room furniture

Designed in modern key to meet widely varying needs in room arrangement, line has been introduced by Carrom Industries, Inc. It is called the "Kaleidoscope" line because of the versatility available in over-all arrangement, as well as individual pieces. For instance, this case illustrated may be utilized in any of 72 combinations to suit specific room needs. Other pieces included are beds, tables, stools, benches, overbed tables, ottomans, and nine types of side and arm chairs. Unity in design and easy interchangeability permit users to quickly re-arrange furniture without the necessity of resorting to "odd" pieces or sacrificing over-all design and harmony. Complete information on all individual pieces can be obtained by checking No. 969 opposite page 66.

for

PATIENTS IN PAIN

longer lasting

LEVO-DROMORAN
Tartrate 'Roche'

for potent, prolonged analgesia

a more profound effect than morphine with a duration of 6 to 8 hours.

for preoperative narcosis... postoperative pain relief...the alleviation of severe, intractable pain.

LEVO-DROMORAN®—brand of levorphan (3-hydroxy-N-methylmorphinan).

faster acting

NISENTIL
Hydrochloride 'Roche'

for brief, rapid-acting analgesia

induces pain relief in 5 to 10 minutes with effect lasting average of 2 hours.

for analgesic effect during minor surgery...during endoscopic procedures...during labor.

NISENTIL®—brand of alphaprodine (1,3-dimethyl-4-phenyl-4-propionoxypiperidine).

HOFFMANN-LA ROCHE INC · ROCHE PARK · NUTLEY 10 · NEW JERSEY

Levo-Dromoran and Nisentil have the same contraindications as morphine; both may be habit forming; narcotic blank required.

BUYER'S GUIDE

Continued

970. Baby dish won't break, keeps food warm

A rubber water jacket encases the sides and bottom of the porcelain dish. When the jacket is filled with water, food keeps warm indefinitely. A rubber stopper, which baby can't remove, plugs the water vent. To keep the plate in place, the dish is pressed firmly on any surface. The rubber suction base holds the dish securely and baby can't tip it or push it over on the floor. Sturdy rubber jacket protects the dish from breaking and keeps it well insulated. There's no metal cover to burn tender hands. Three different foods can be placed in the separate deep compartments without mixing. Kingsbury Products Co.

971. Remove hospital odors

"Allright" products for odor control are specially formulated for use in hospitals, sanatoriums, clinics, and other institutions. Can be used in wards, sickrooms, on dressings, in employee rooms, laboratories, animal care department, storage, and lavatories. Lessens discomfort of caring for patients with strong unpleasant odors. For complete information on this line of products, check the postpaid reply card facing page 66. "Allright" Chemical Co.

972. Telfa bandages peel off without pain

This is a non-woven highly-absorbent cotton fabric sealed to a plastic (non-wettable film of Mylar, DuPont's polyester) which is precisely pierced with perforations big enough for rapid permeation of drainage, yet small enough to exclude completely granulating tissue that causes a gauze bandage to cling to an open wound. The film side of the dressing is placed next to the wound, with the soft cotton fabric on the outside. The discharge is sucked up through the perforations by pump-like action. The absorbency of the cotton fabric holds the discharge and does not let it drain back onto the wound area. Bauer & Black.

973. Cleaning compound for shower stalls

Quick means of removing unsightly discoloration and keeping shower stalls clean with little effort is afforded in a chemical compound being made available by Berman Chemical Co. Algae accumulation, lime deposits, iron rust stains, soap oil, and body grease are removed without hard rubbing or scrubbing. Cleaning is by chemical action.

965. Instrument lubricant of silicone

It's heatproof at autoclave temperatures and above. It is a rust preventive. Sil-Spray is pure silicone in a convenient aerosol bomb. A whole trayful of instruments may be lubricated in seconds. It is economical because a light spray coat is enough. Squirt it into door and auto locks. Spray ice trays, griddles, electric irons to prevent sticking. Duxe Products.

974. Square sterilizer increases capacity

A 35%-100% increase in usable sterilizer capacity (depending upon type of load) compared with the conventional cylindrical sterilizer counter-parts. This is considered fundamentally a labor-saving device by the American Sterilizer Co. By increasing the loading capacity of the sterilizer without increasing the maintenance burden or occupied floor space, the sterilizer operator makes fewer trips to the sterilizer to load, unload, and then reload the machine for an additional cycle. This model features heat reduction, economy, appearance, and conserves floor space.

FROM EVERY ANGLE THE

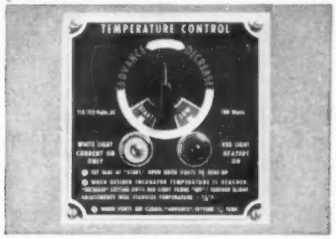
New Penn "600"

INCUBATOR of CHOICE

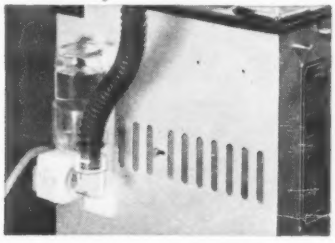
Provides a constant heat level throughout the infant compartment with accurate high humidity control . . . plus unusually convenient facilities for infant care.

Infant Care . . .

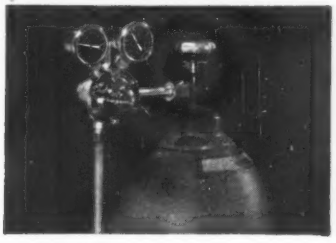
Temperature . . .



Humidity . . .



Oxygen . . .



Write Dept. HE-11

AMERICAN STERILIZER

Erie • Pennsylvania

BUYER'S GUIDE

Continued

984. Reservoir type oral mask

The Air-O-Sol mask is medically engineered to provide a simple and inexpensive, but effective, method of administering various aerosols by oral inhalation whenever an enclosure area, such as a tent, is not indicated. Specifically designed to eliminate the dangers of oxygen or CO^2 toxicities. Patients breathe freely without any increased resistance as there are no built-up pressures or restricted inlets in mask. Treatment of claustrophobic patients facilitated as patients' nasal airways are never covered. Eliot Medical Plastics, Inc.

985. Serve ice cream in thermal bowl

Patients may be served ice cream in hospitals with this new bowl which has a fully insulated double walled stainless steel container. Also ideal for soups and cereals, as it keeps foods warm as well as cold. High polished stainless steel, crevice-free, and with double wall construction. No matter how many times it is dropped it will not break. There are no fillers to replace; can be washed in any commercial washer. Designed to "stack" on one another. Landers, Frary & Clark.

986. Maintenance of giant cancer killer

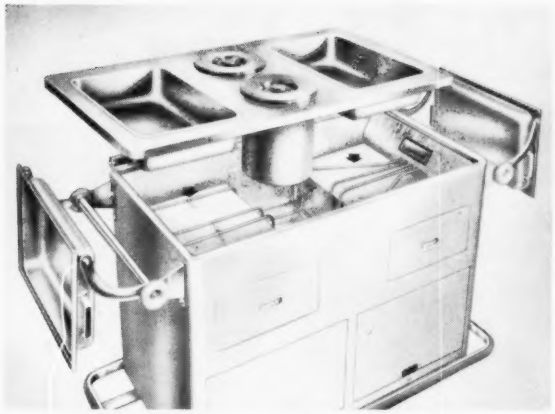
Servicing a giant five-ton Betatron, one of science's newest weapons against cancer, is simplified at New York's famous Memorial Center for Cancer and Allied Diseases by use of a Yale industrial hoist. The Betatron, which shoots 24 million electron volt x-rays at deeply seated cancers, is made up of numerous massive parts which maintenance technicians cannot lift out by hand. Using a Yale three-ton spur-geared block mounted on an overhead rail, two maintenance technicians (above) are about to lift a lead door weighing 275 pounds from the machine. The huge internal magnets and the heavy motors which turn the machine into proper position for treatment or research experiments also can be removed by means of the hoist for periodic maintenance. These facts were reported to HOSPITAL TOPICS by the Yale & Towne Mfg. Co., manufacturers of this device.

993. New model photofluorometer

A new photofluorometer has been added to the Coleman Instruments, Inc. line of fluorimetric instruments. According to the manufacturer, the new model offers greatly increased sensitivity and improved stability which enable it to deliver accurate data both at very faint fluorescence levels and lower concentrations than those previously convenient to handle. For further information, check No. 993 on the post-paid reply card facing page 66.

987. Keeps glass clean up to 14 days

New Klear-Glass keeps visibility unobscured. Immediately following application, glass, plastic and tile surfaces will remain fog-free, steam-free, dust-resistant, and optically brilliant for periods up to 14 days. Wide hospital and private office uses, recommended by the Buckley Corp., include x-ray screens, eye glasses, scrub-up room, nursery visitors window, floor stations, laboratory ware, glass paneled cabinets, scientific instruments, mirrors, surgical lighting optics, equipment dials and gauges.



977. Electrically-heated conveyor

Top removed from Blickman-built strip heaters which distribute heat uniformly through all surfaces of wells, sidewalls, as well as bottoms. Heating is quicker, food remains piping hot at controlled temperatures. Heating elements can be replaced in minutes if necessary. The heaters are guaranteed for a minimum of five years. S. Blickman, Inc.

978. New "no carbon required" paper

Now you can have business forms that make legible copies without using carbon paper. Special paper prints duplicate copies, but is easier to use, faster, and more smudge-free than carbon paper. For sample literature check No. 978 on reply card facing page 66.

964. High speed blendor

Designed for the medical laboratory field, it is capable of high speed blending, pulping and mixing in larger quantities than handled by previous models. The Central Scientific Co. also states that it is the first high speed blending device capable of holding more than 27 ounces. It has five speeds and is operated with automatic push-button controls. Speeds range from 8,000 rpms. to 16,000 rpms. For information on other features of this blendor, check No. 964 on the Buyer's Guide post-paid reply card facing page 66.

NEW LITERATURE, FILMS

988. New laboratory apparatus bulletin. Lanco Apparatus News for October, features more than two dozen items of laboratory equipment. Included are Stuart and Briegleb atom models, apparatus for sub-sieve range particle size analysis, test sieve vibrator, balance with 311-gram capacity, infra-red water bath, and lattice rod support clamps. 12 pages. Arthur S. LaPine & Co.

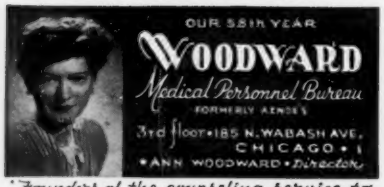
979. Storage and maintenance equipment catalogue. Decribes in 16 pages many new items added to the Bernard Franklin Co., Inc. standard line of steel shelving, cabinets, bins, trucks, stools, and other storage and maintenance equipment. Has detailed information on applications, construction, and specifications to aid in solving storage or handling problems.

980. Storage and maintenance equipment catalogue. Published in 24 pages, it includes new items added to Precision Equipment Co.'s standard line of lockers, ladders, steel shelving, and storage and maintenance equipment for industrial and institutional uses. Features work of nationally famous cartoonists.

981. "The Open Method of Burn Therapy" is the latest of two teaching films on the subject of burns, that are available on loan to professional groups from Paul F. MacLeod, M.D., Eaton Laboratories. It was prepared by John C. Weeter, M.D., instructor in plastic surgery, University of Louisville School of Medicine, and illustrates the technic of open treatment, including the progress of one patient who suffered burns over 62 percent of his body. The other film is **"Skin Grafting of Extensive Burns,"** prepared by Harry R. Grau, M.D., University of Kansas Medical Center.

982. Film tells success of high school girls' aid to hospitals. A color film, telling in picture and words the remarkable success of an Akron, Colorado girls' club organized to aid and support the Washington County Hospital, has been produced and made available to the public by the Colorado Blue Cross and Blue Shield Plans. For more information about this interesting film, check No. 982 on the reply card facing page 66.

CLASSIFIED



Founders of the counseling service to the medical profession, serving medicine with distinction over half a century.

POSITIONS OPEN

ADMINISTRATORS: (a) Lay or medical; 500 bed hosp; MW city of 200,000; sal open. (b) Lay; lge Calif hosp; bachelor's degree with good acctg background desired. (c) Lay; vol gen'l hosp; 100 beds; lovely twn nr metropolis; E. (d) Lay; gen'l hosp in last stages of construction; 250 beds; immediate appt; coll twn 100,000 (e) Lay; import Med. center; 2 units; 400 beds; teach prog; residential twn 40,000 nr metropolis; E. (f) Lay; 125 bed vol gen'l hosp; county seat 40,000; MW. (g) Exec vice-pres; import Hosp assoc; req's man of Senior Exec caliber with hosp legislative and organization exper; hdqtrs lge city.

ADMINISTRATORS: BUSINESS MANAGERS: (a) Under 40; excel clinic; Pacific NW (b) Import outpatient clinic; to $12,000; univ. twn 120,000; Mid-west. (c) 9-man grp; air cond clinic; beaut Fox River valley twn; 1 hr from Chgo. (d) 5-man grp; Missouri.

ADMINISTRATORS: MISCELLANEOUS: (a) Comptroller, resp acct'g, credit and collections; req's deg in Hosp Adm, Bus Adm or Acc't; 500 bed hosp Mid-west. (b) Personnel and Public Relations mgr; exp in indus pers, as well as hosp pers req'd; lg hosp Mid-west; high caliber man will find broad scope of oppty. (c) Personnel Director and Admitting Officer; new post; 350 bed hosp; approx 500 employees; coll twn, SE. (d) Personnel Manager; 7 empl in personnel dept; to 1,800 employed in hosp; Mid-west; to $8,000.

ADMINISTRATORS: PURCHASING AGENTS: (a) New gen'l hosp; 260 beds; Calif. (b) 250 bed hosp; Mid-west.

ANESTHETISTS: (a) Vol gen hosp 50 beds; oppty do free lance wk; fee basis, totalling 80% collections; resort and coll twn; W-central. (b) Apprv'd 200-bed gen hosp; to $6,000; twn 7,000; Carolinas. (c) Vol gen hosp 120 beds; gd sal; noted SW med center. (d) By 2 man clin grp; surg perf at sm gen hosp and med sized TBc hosp; Alaska.

DIETITIANS: (a) Food Mgr; 500,000 mls served annually in 300 bed gen hosp; to $6,000; city 400,000; SE. (b) Chief; modern and well equip'd dept; new 130 bed vol gen hosp; excel facil; $6,000 min; univ city; SW. (c) Chief; 2 assts; new 200 bd gen hosp; all electric kitchen; attrac resort twn; Fla. (d) Admin food serv mgr; lge apprv'd gen hosp; $5,400 start; attrac city 150,000; MW.

EXECUTIVE HOUSEKEEPERS: (a) To also serve as ldry manager; super 20 people; med sized gen hosp; $500 start; W. (b) Lge gen hosp; 135 bd addition opening soon; univ city; MW. (c) 200 bed gen & TBc hosp; apprv'd JCAH; mtce avail; resort city; SW.

SUPERVISORS: (a) OR; teach'g req'd; fully apprv'd 300 bed gen hosp; Calif. (b) OB; admin 35 bd unit w/40 bass; new 300 bd gen hosp; resort twn nr NYC. (c) OR; 500 procedures pr mo in air cond surg suite; staff of 30; lge gen hosp; twn 40,000; Carolinas.

Personally Speaking

Richard M. Hewitt, M.D. (center), senior consultant, section on publications, Mayo Clinic, Rochester, Minn., answers questions of Paul Sieber (l.), Jordan-Sieber Associates, Chicago, and J. J. Klocke, vice president, The Hensley Co., Chicago, on new college courses in medical journalism following meeting of Midwest Pharmaceutical Advertising Club in Chicago. Dr. Hewitt received 1954 distinguished service award of the American Medical Writers' Association.

Nicholas M. Alter, M.D.—has been appointed full-time pathologist, Blessing Hospital, Quincy, Ill. He formerly was director of laboratories, Margaret Hague Maternity Hospital, Jersey City, N. J.

Jack Angel — formerly administrator, New Valley Osteopathic Hospital, Yakima, Wash., is the new administrator, Pioneer Memorial Hospital, Heppner, Ore. He replaces **John B. Ernsdorff,** who resigned to accept the position of administrator, St. Joseph's Hospital, Lewiston, Idaho.

Harry E. Apgar — has succeeded **Leonard Freda, M.D.,** as superintendent, Scranton (Pa.) State Hospital. He formerly was vice president, West Side Hospital, Scranton.

Elbert P. Barnes — formerly business manager, Highland Hospital, Asheville, N. C., has become administrator, Bamberg County (S. C.) Memorial Hospital. He succeeds **Lewis E. Bates,** who has taken a position with an Atlanta surgical supply firm. Mr. Bates is also taking a special course in hospital administration at Emory University, Atlanta.

Alvin J. Binkert — has been appointed vice-president and general manager, The Presbyterian Hospital, Columbia-Presbyterian Medical Center, New York City, to succeed the late **John S. Parke.** Mr. Binkert, who has been associated with Presbyterian Hospital for almost 20 years, was formerly assistant vice-president of administration.

Robert G. Blackwelder, M.D.—formerly of Western State Hospital, Hopkinsville, Ky., has been appointed clinical director, Southwestern State Hospital, Marion, Va.

Norman A. Brady — formerly director of the Methods and Improvement program, St. Luke's Hospital, Chicago, has been appointed assistant director, Presbyterian Hospital, Chicago. Before coming to St. Luke's in 1953, Mr. Brady managed the 1,800-bed Sunnybrook Hospital, Toronto, Can.

Margaret Lee Cavey—formerly administrative nursing supervisor, neuropsychiatric service, McGuire VA Hospital, Richmond, has been appointed director, psychiatric nursing education, Southwestern State Hospital, Marion, Va. She replaces **Genevieve Noble,** who resigned to become

(Continued on page 64)

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PERSONALLY SPEAKING continued

director of nurses, Yale Psychiatric Institute.

Felicia Mary Cimino — formerly head anesthetist, Woman's College Hospital, Philadelphia, has been appointed anesthetist at the new Tyrone (Pa.) Hospital.

Katharine Crossin—formerly physical therapist, Ohio Society for Crippled Children, Columbus, O., has assumed a similar position at Les Passees Treatment Center for Cerebral Palsied Children, Memphis, Tenn.

Ward B. Edwards — formerly an administrative assistant, Mary Fletcher Hospital, Burlington, Vt., has been named assistant to the administrator and purchasing agent, Middlesex (Conn.) Memorial Hospital. He succeeds **Robert F. Tuveson,** who has been appointed assistant administrator, Springfield (Mass.) Hospital.

David Einbinder, C.P.A.—has been appointed comptroller, Griffin Hospital, Derby, Conn., succeeding **Ralph C. Booth,** who resigned because of ill health.

Walter J. Friday — superintendent of maintenance, Noxubee (Miss.) General Hospital, has resigned to enter the University of Georgia at Atlanta for a course in hospital administration. Mr. Friday has been at Noxubee General Hospital for two and one-half years.

Lee C. Gammil — recently resigned as administrator, Texas Children's and St. Luke's Episcopal Hospitals, Houston, owing to ill health.

J. T. Grantham — executive assistant, Mississippi Baptist Hospital, Jackson, Miss., has resigned.

John W. Green—formerly administrative resident, Indiana University Medical Center, Indianapolis, has become administrator, Guernsey Memorial Hospital, Cambridge, O.

Harold N. Griswold—formerly assistant executive housekeeper, Hartford (Conn.) General Hospital, is now executive housekeeper, St. Francis Hospital, Hartford, Conn.

Rose C. Hapich, R.N.—formerly assistant director of nursing, Elizabeth (N. J.) General Hospital, has been named director of nursing, Lower Bucks County (Pa.) Hospital.

Emil L. Herbert—president, American Osteopathic Hospital Association, has been appointed administrator, Normandy Osteopathic Hospital, St. Louis, Mo. He succeeds the late **Mrs. Agnes L. Drewel,** who was killed in an automobile accident last Spring.

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NURSE ANESTHETISTS: (a) South. 100 bed hospital, new modern. $400 plus maintenance. (b) Northwest. Administrator-Anesthetist. 20 bed hospital in small modern farming community. $400 plus maintenance. (c) Middle West. 150 bed hospital. 4 in department. $500. (d) Middle West. Medium sized hospital in college town. $600. (e) Pacific Northwest. 100 bed hospital. $500-maintenance. (f) Middle West. 300 bed hospital in large city. Fully approved. $500. (g) South. New Modern 100 bed hospital; approximately 100 major and 200 minor operations a month. $450 plus maintenance. (h) South. 250 bed hospital, fully approved. Department under supervision of an anesthesiologist; 4 nurse anesthetists. Salary is open and will include full maintenance.

DIETITIANS: (a) Chief. Middle West. 120 bed fully approved hospital located in a pleasant community of about 20,000. Dietary department well staffed and modern in all respects. $6,000. (b) Chief. Southwest. Large hospital. Good training in nutrition. Hotel or restaurant food service management would be helpful. Cafeteria will seat 225. Operate with all packaged food service. $6,000 minimum. (c) Chief. East. 500 bed hospital. 70 employees in department. Manage dietary department and supervise teaching program of nursing school. $6,000. (d) Assistant. East. 260 bed general hospital, fully approved. Good opportunity for advancement. $4,400. (e) Assistant. East. 180 bed hospital. Kitchen entirely new and modern in all respects. $4,800.

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Mr. Herbert formerly was administrator, Chicago Osteopathic Hospital.

Guillermo P. Herrera, M.D. — has been appointed assistant pathologist, Decatur and Macon County (Ill.) Hospital. He formerly was assistant pathologist, St. Charles Hospital, Toledo, O.

Robert Kroessin — has resigned as administrator, Pioneer Memorial Hospital, Prineville, Ore. **Mrs. Thelma Elliott**, formerly bookkeeper at that hospital, is now acting administrator.

Sister Margaret—formerly administrator, O'Connor Hospital, San Jose, Calif., has been appointed to an administrative position at Charity Hospital, New Orleans, La.

Helen Marsh—formerly educational director, St. Joseph's Hospital School of Nursing, Omaha, Nebr., is now state director of Education and Registration for Nurses, Lincoln, Nebr.

H. K. Moir, M.D. — has been appointed superintendent, Rollman Receiving Hospital, Cincinnati, O. He formerly was senior psychiatrist, the VA Hospital, Marion, Ind.

Paul E. Moore—formerly chief technician, Clarksville (Tenn.) Memorial Hospital, has been appointed administrator, Trigg County Hospital, Cadiz, Ky. He succeeds **Carl S. Napps** who resigned to attend the School of Hospital Administration, Medical College of Virginia, Richmond.

Evelyn J. Motley—formerly chief dietitian, Fairmount (W. Va.) General Hospital, is now chief dietitian, Overlook Hospital, Summit, N. J.

Major Inga Saugen, R.N.—formerly superintendent of the Salvation Army's Booth Memorial Hospital, Spokane, Wash., has been transferred to western headquarters in San Francisco. Her successor is **Capt. Gwen Carrothers** of Boise, Idaho.

Robert H. Southcombe, M.D.—superintendent, Eastern Hospital, Medical Lake, Wash., has resigned.

Anne D. Taylor, R.N. — formerly director of nursing, General Hospital, Louisville, Ky., is now director of nursing, University of South Dakota, Vermillion.

Leo Tepper, M.D. — has been appointed associate chief of professional services, City of Hope National Medical Center, Los Angeles. Dr. Tepper, who is presently director, department of chest diseases at City of Hope, will continue in this capacity for the present while assuming his new duties.

Eugene F. Traub, M.D.—has been appointed medical director, Skin and Cancer Hospital, Philadelphia. Dr. Traub, a nationally acknowledged authority on skin cancer, was formerly professor of dermatology, New York Medical College.

Mrs. Ruth Walthall, R.N.—has been appointed supervisor of nursing, and **Mrs. Margaret Middlebrooks, R.N.**, assistant supervisor of nursing at Macon (Ga.) Hospital. Both Mrs. Walthall and Mrs. Middlebrooks are graduates of that hospital's nursing school.

Agnes Youngblood — has resigned as director of nursing service, Petersburg (Va.) General Hospital.

Stanley Zacharias—has become assistant director of the clinical laboratory, The Myers Clinic Hospital, Philippi, W. Va., succeeding **Gordon Starkey**, who resigned to accept a position at St. Luke's Hospital, Cedar

(Continued on next page)

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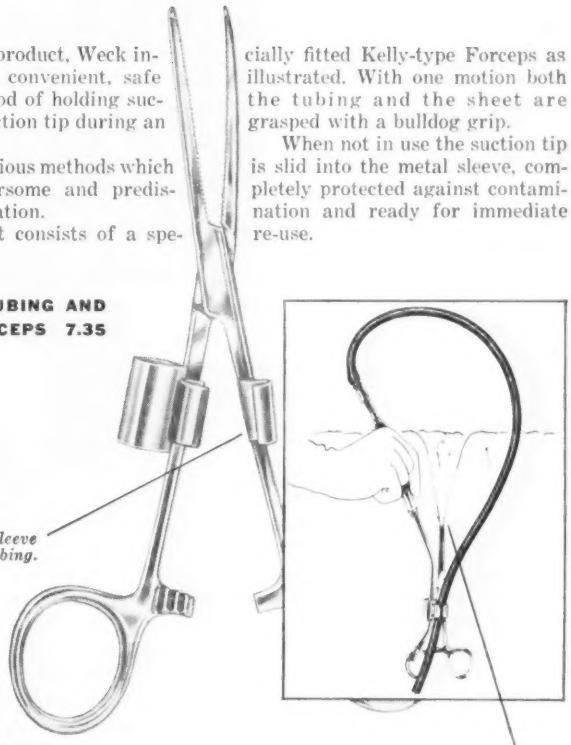

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Department of Surgery
St. Clare's Hospital, New York.

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Rapids, Ia. Mr. Zacharias formerly was associated with Washington County Hospital, Hagerstown, W. Va.

VA Appointments

Jack M. Burnett, M.D. — has been appointed chief of laboratory service, John J. Cochran VA hospital, St. Louis. He formerly was chief of laboratory service, VA hospital, Baltimore.

William W. Fellows — formerly manager, VA hospital, Albany, N. Y., has been appointed manager, VA Research Hospital, Chicago.

Frank Merker, M.D.—has been promoted to assistant chief of professional services, Winter VA Hospital, Topeka, Kan. He formerly was chief of continued treatment in Section C of that hospital.

VA Nursing Appointments

Elizabeth Breor, R.N.—is assistant chief, nursing service, Manhattan VA Hospital, New York City. Prior to leave for educational purposes, she was at Jefferson Barracks, Mo.

Henrietta M. Carlson, R.N.—is assistant chief, nursing service and education, VA hospital, Miles City, Mont.

Jane A. Eaton, R.N. — is chief, nursing service, VA hospital, Bedford, Mass. Prior to leave for educational purposes, she was chief, nursing service, VA hospital, Battle Creek, Mich.

Eva Y. Gladhue, R.N. — has been transferred to VA hospital, Buffalo, N. Y., as chief of nursing service. She formerly was chief, nursing service, VA Center, Jackson, Miss.

Nicholas J. Hasenstab, R.N. — formerly acting chief, nursing education, VA hospital, Tomah, Wisc., is now assistant chief of nursing education at that hospital.

Hilda D. Helmke, R.N.—is assistant chief, nursing education, VA hospital, Indianapolis, Ind. She formerly was an assistant professor, Michigan State College, East Lansing, Mich.

Marjorie M. Howard, R.N.—is assistant chief, nursing education, VA Center, Waco, Tex. She formerly was a member of the staff, Larve D. Carter Memorial Hospital, Indianapolis, Ind.

Blanche C. Jackson, R.N.—formerly head nurse, GM&S Hospital, Salt Lake City, Utah, is now assistant chief of nursing service at that hospital.

Enola M. Jermyn, R.N.—is assistant chief, nursing education, VA Center, Biloxi, Miss. She formerly was an instructor at that hospital.

Madeline A. Kennedy, R.N. — has been transferred as assistant chief, nursing education, VA hospital, Boston, to a similar position at VA hospital, Buffalo, N. Y.

Martha T. Knutson, R.N. — is now chief, nursing service, VA hospital, Poplar Bluff, Mo., replacing **Marie Megary, R.N.**, who has become chief, nursing service, VA Center, Biloxi, Miss. Miss Knutson formerly was assistant chief, nursing service, VA hospital, Ft. Wayne, Ind.

Grace W. Leutsch, R.N.—formerly assistant chief, nursing education, VA hospital, Marion, Ind., is now chief of nursing service at that hospital.

Rosina I. Magee, R.N. — is now chief, nursing service, VA hospital, Montgomery, Ala. Prior to transfer, she was assistant chief, nursing education, VA hospital, Columbia, S. C.

Mary J. McCarthy, R.N.—formerly assistant chief, nursing service, VA hospital, Denver, is now chief of nursing service there.

(Continued on page 67)

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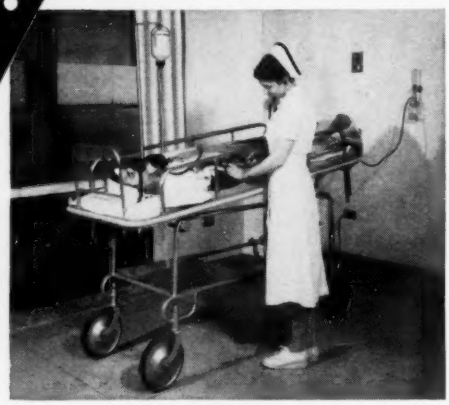

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970. Baby dish won't break, won't tip, keeps food warm.
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975. Steam-Chef can accommodate standard steaming baskets.
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980. Catalogue on Precision Equipment Co.'s products lists new items.
981. Two latest teaching films on burns available on loan.
982. Color film of high school girls' aid to Akron, Colo., hospital.
984. Mask used for administering various aerosols by oral inhalation.
985. Insulated, stainless steel serving bowl keeps foods hot or cold.
986. Yale industrial hoist used for servicing giant Betatron.
987. New product keeps glass, plastic and tile fog-free, steam-free, dust-resistant.
988. New laboratory apparatus bulletin features more than two dozen items of equipment.
994. Thermoplastic coated cloth tapes splice and reinforce.
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953.	960.	967.	974.	981.	994.
954.	961.	968.	975.	982.	995.
955.	962.	969.	976.	984.	996.
956.	963.	970.	977.	985.	
957.	964.	971.	978.	986.	
958.	965.	972.	979.	987.	

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953.	960.	967.	974.	981.	994.
954.	961.	968.	975.	982.	995.
955.	962.	969.	976.	984.	996.
956.	963.	970.	977.	985.	
957.	964.	971.	978.	986.	
958.	965.	972.	979.	987.	

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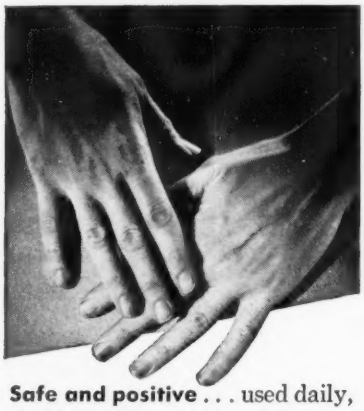

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PERSONALLY SPEAKING continued

Elizabeth K. McLaughlin, R.N. — formerly chief, nursing service, VA Center, Biloxi, Miss., is now chief, nursing service, VA Center, Jackson, Miss.

Elise Meyer, R.N.—is chief, nursing service, VA hospital, Murfreesboro, Tenn. She formerly held a similar position at VA hospital, Bedford, Mass.

Irma M. Olson, R.N. — formerly assistant chief, nursing education, VA hospital, Birmingham, Ala., is now assistant chief, nursing education, VA hospital, Boston.

Helen I. Tadowsky, R.N. — is chief, nursing service, VA hospital, Erie, Pa. She formerly was acting chief of nursing service there.

Catherine M. Treusch, R.N.—is now chief, nursing service, VA hospital, Battle Creek, Mich. She formerly was acting chief of nursing service at that hospital.

Raymond C. Veselak, R.N.—is assistant chief, nursing education, VA hospital, Marion, Ind. He formerly was an instructor there.

Helen E. Wysocki, R.N.—formerly assistant director, nursing service, Saint Mary's Hospital, Grand Rapids, Mich., has been assigned assistant chief, nursing education, VA hospital, Erie, Pa.

Oma E. Yaste, R.N.—has been reassigned as chief, nursing service, VA hospital, Grand Junction, Colo., upon return from military duty.

Deaths

Loyd J. Eppenbaugh—43, manager, Eugene (Ore.) Children's Hospital School, died August 27.

A. H. Graham, M.D.—54, who directed the nation's first mass use of gamma globulin during a severe polio outbreak in Montgomery, Ala., in 1953, died August 18.

Oswald Kopal — 65, purchasing agent, Hermann Hospital, Houston, died Sept. 8.

Charles McMartin, M.D.—74, head of the department of surgery, Creighton University, Omaha, Nebr., and a past president of the American Urological Association, died Sept. 14.

James W. Manary, M.D. — 70, former superintendent, City Hospital, Boston, died Sept. 15.

Harry Thurston Maxwell, D.O.—68, president of the board of health, Morristown, N. J., died Sept. 20. He was past president of the New Jersey Association of Osteopathic Physicians and Surgeons.

(Continued on page 84)

CHA Advisory Committee Meets in St. Louis

The first meeting of the newly established Medical Advisory Committee of the Catholic Hospital Association was held in St. Louis on October 2.

Members of the recently appointed committee include Edward H. Bowdern, M.D., St. Louis; R. J. Bozzo, M.D., Washington, Mo.; Joseph V. Finnegan, M.D., St. Louis; Frederick M. Gillick, M.D., dean, Creighton University School of Medicine, Omaha; and Rev. John J. Humensky, diocesan director of hospitals, Cleveland.

Others are William J. Lahey, M.D., director, medical education, St. Francis Hospital, Hartford, Conn.; Sister Loretto Marie, R.S.M., administrator, Mercy Hospital, Chicago; and Louis S. Smith, M.D., Dallas. Robert S. Myers, M.D., assistant director, American College of Surgeons, Chicago, is consultant to the committee.

The committee was established to provide medical advice to the 1,500 hospitals in the CHA, and to work toward closer liaison between the hospitals and the medical staffs. The group will also assist with education programs for interns and residents, and will help organize medical staffs and encourage research.

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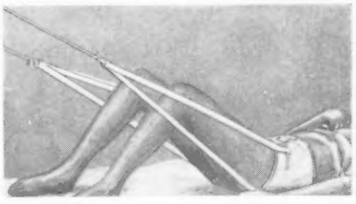

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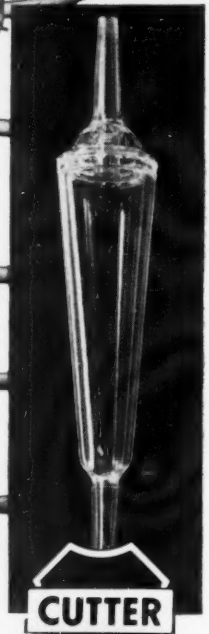

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ILLINOIS OPERATING ROOM NURSES have voted to form a state section in the Illinois State Nurses' Association. Thirty-three nurses, representing seven out of 13 districts, attended the organizational meeting, held during the annual convention of the Illinois State Nurses' Association. Officers of the new section, shown above, are, standing (l. to r.): Mrs. Mary Aline Brian, Decatur and Macon County Hospital, committee on nominations; Margaret Young, South Chicago Community Hospital, executive committee; Mrs. Vivian Baron, Kankakee State Hospital, committee on nominations; and Jean Becker, St. Francis Hospital, Peoria, second vice-chairman. Seated: Sister Ethelburga, St. Francis Hospital, Peoria, first vice-chairman, and Evelyn J. Owens, Chicago Wesley Memorial Hospital, chairman.

Not present for the picture were Louise Rzeszewski, Cook County Children's Hospital, Chicago, secretary; Eldrid Kemmer, VA Hospital, Dwight, executive committee; and Evelyn Kienask, Lake View Hospital, Danville, committee on nominations. Featured on the program was a discussion of recovery rooms, which will be reported in an early issue of HOSPITAL TOPICS.

See program for Second National Conference, Association of Operating Room Nurses, opposite page 42.

Nurse Anesthetists Convene in Chicago

● *From the 21st annual convention of the American Association of Nurse Anesthetists, which met in Chicago, Sept. 13-16, HOSPITAL TOPICS presents abstracts of some of the important papers.*

What Anesthetists Should Know About Heart Conditions

Samuel Rosenthal, M.D., Assistant Professor of Medicine, Marquette University School of Medicine, Milwaukee, Wis.—Common forms of heart disease which the anesthetist encounters are: mitral and aortic stenosis and insufficiency; hypertensive heart disease; coronary arteriosclerosis; congenital heart disease, and thyroid and syphilitic heart disease (less common).

Before giving an anesthetic to a heart patient, the anesthetist should check:

(1) The history sheet for an enlarged liver, shortness of breath on rest or effort, swelling of the ankles, cough, sleeping on several pillows at night, and taking of digitalis or injections to help pass urine.

(2) The physical examination for rales, cyanosis, high blood pressure, irregularity of heart.

(3) The laboratory examination for red blood count and hemoglobin, electrocardiogram, chest x-ray, and BMR.

The clinical history, not the ECG, determines whether the patient is a good risk or not. The ECG is of value in determining the type of arrhythmia or irregularity present. A chest x-ray may show an enlarged heart and pulmonary congestion or deviation of trachea by thyroid or other mass. An elevated BMR suggests the need for extra oxygen.

If an operation must be performed in spite of congestive failure, the anesthetist should (1) give no saline solution during the operation; (2) avoid giving large amounts of fluid during the operation (1,500 cc. generally is sufficient); (3) avoid large doses of spinal anesthetic or a high spinal.

Adequate oxygen should be administered for the duration of anesthesia, but changes in concentration of oxygen from high to low should be avoided. Blood pressure should be taken every five minutes. A rise denotes oxygen want or carbon dioxide excess.

Cyclopropane should not be used when adrenalin has been administered with local novacaine anesthetic, because of the danger of arrhythmia. Ethylene and ethylene ether mixtures are safe for cardiac cases if oxygen content is adequate. Spinal anesthesia should be avoided.

Before leaving the dinner, Sister Rudolpha, R.N., (l.) pauses for a last look with Sister Seraphia, R.N., holding souvenir balloons. Both sisters are from St. John's Hospital, Springfield, Ill.

Anesthesia and Airway Problems In Polio Patients

E. Trier Morch, M.D., Professor and Director of Anesthesia, University of Chicago School of Medicine—Poliomyelitis cases can be classed as (1) those with normal respiration; (2) those with moderate respiratory difficulties, and (3) those with severe respiratory difficulties.

When respiration is normal, the patient is no different from any other. When moderate difficulties exist, avoid depressants and use a local and ether, with intubation when in doubt. In severe cases, keep the patient in the respirator during induction and intubation, and breathe for him at all times.

Relaxants are rarely necessary, because the patient is already relaxed by the disease. Disinfect equipment by boiling, autoclaving, antiseptics, and ultraviolet light. The virus is easy to destroy.

Often the most critical patients have the best prognosis, if we can carry them through the first week of terrific danger.

Anesthesia for Geriatric Surgery

Ethelyn McFarland, R.N., and Elaine McMurdie, R.N., Anesthesia Department, Butterworth Hospital, Grand Rapids, Mich.—A series of 748 cases in a five-year period, with the patients 70 years or over, was analyzed.

The patients suffered the usual degenerative diseases. Hypertension and heart disease were the most common. Emphysema frequently associated with asthma, chronic bronchitis, and bronchiectasis were the usual respiratory complications.

Premedication was usually Demerol and atropine or scopolamine. Barbiturates were avoided.

Anesthetic agents and methods were the same used on any adult group, considering the physical status of the patient and the surgery to be performed. In the last three years, combined anesthetics were used more often, especially in the 70-79 age group.

When Pentothal was used in smaller doses than usual for an adult, it could be safely given to patients over 65. There were the usual anesthetic complications, such as laryngospasm, bronchospasm, and arrhythmias. Reflex hypotension was observed and was associated with deep anesthesia on several occasions.

The types of surgery were: perineal, 315; extremity, 121; lower abdominal, 110; upper abdominal, 92; operations about head, 47; miscellaneous, 63. Ninety-one patients received two or more anesthetics.

Two patients died in the operating room, and six

others died within eight days. The greatest cause of death was of cardiovascular origin. Four patients had been given nitrous oxide-oxygen-ether, and four, Pentothal-curare nitrous oxide-oxygen.

Induced Hypotension

Donald E. Hale, M.D., Chief, Department of Anesthesia, Cleveland Clinic—Induced hypotension is a safe, valuable, and sometimes essential procedure. Safety depends upon close observation and control, and upon a lowered blood pressure level being maintained as short a time as possible.

Controlled induced hypotension is used for four purposes: (1) to reduce blood pressure and conserve a patient's blood; (2) to provide a clear field unobstructed by blood; (3) to reduce brain edema, and (4) to reduce the tension in large vessels which are being operated upon.

The need for saving blood is indicated by the following average blood loss in some of the standard procedures: craniotomy, 803 cc.; radical mastectomy, 690; thoracotomy, 1,558; operation on bile ducts, 460; nephrectomy, 484, and hysterectomy, 358.

A clear field is especially desirable in intracranial procedures and in the fenestration operation. The reduction of brain edema is of considerable value whenever it is encountered during intracranial surgery.

Hypotension is induced by arteriotomy, spinal anesthesia, or use of ganglioplegic drugs. In a series of 50 cases of hypotension by arteriotomy, the quantity of blood varied from 800 cc. to 3,000 cc.; the average was 1,742. The average fall in mean blood pressure was 43.5 mm. Hg.; the average withdrawal time, 29.4 minutes. The average time the blood remained outside the body was 25.7 minutes.

The dangers of hypotension are the result of the effect of low blood pressure upon different body systems. Therefore, both duration of the hypotension and the levels of the blood pressure must be considered. It is important to have an accurate means of reading pressure at low levels.

Anesthesia for Paraplegic Patients

R. Anthony Tella, M.D., Chief of Anesthesia Service, VA Hospital, Wood, Wis. — As a result of improved technics and introduction of antibiotics, a large number of patients survived spinal cord injuries in World War II. Between 80 and 88 percent of soldiers incurring such injuries returned to paraplegic centers, and there has been a mortality of only two to eight percent.

Only a very small percentage of paraplegics coming to surgery need to be anesthetized. As a general rule, operating procedures below the cord lesion can be completed without anesthesia. One of the main complications of the paraplegic which may require surgery is decubitus ulcer. Such patients who present no tendency to heal under conservative treatment are operated upon. The operation usually entails the radical excision of the ulcer, including oftentimes the underlying bone. Many of these operations are done without anesthetics.

Frequently, however, patients are near panic on being told they are going to the operating room. Our procedure has been to sedate them well, using Nembutal and administering oxygen during the operation. Nembutal is given the night before and also in the morning preoperatively. If this fails, then a drip solution of Pentothal is given. Blood is administered if necessary, mostly because of anemia and hypoproteinemia.

One of the grave complications in paraplegics undergoing operation is paroxysmal hypertension. We have never seen a postoperative cerebrovascular accident provoked by it, but the possibility exists, and we must be on guard.

In our paraplegic series requiring general anesthetics,

(Continued on next page)

A skit based on Chicago's history was presented at the state dinner by Chicago area anesthetists. Highlight was a full dress "high society" wedding from "when Chicago was young." Members of the cast shown below are, kneeling: John F. Quinn (a Charleston dancer), Argonne National Laboratory, Lemont, Ill., and Esther McDermott (Mrs. O'Leary), Walther Memorial Hospital, Chicago. Standing (l. to r.): Ruth Marks (moderator), West Suburban Hospital, Oak Park, Ill.; Jack Joyce (an Indian), Garfield Park Hospital, Chicago; Rose Aiello (Sophie Tucker), St. Anne's Hospital, Chicago; Marie Niccoli (bride), St. Anne's Hospital, Chicago; John Gramyk (groom), St. Elizabeth's Hospital, Chicago; Mary Duray (maid of honor), West Suburban Hospital, Oak Park, Ill.; Lillie Stuffelbeam (bridesmaid), St. Francis Hospital, Blue Island, Ill.; and Matilda Welinske (bride's mother), Resurrection Hospital, Chicago.

L. to r.: Emily Carter, R.N., Lindley Hospital, Duncan, Okla.; Steve Timbers, Eau Claire, Wis.; and Rosella Crotty, R.N., director of anesthesia, Luther Hospital, Eau Claire, Wis.

we found no contraindication for any particular anesthetic agent. We stress careful, skillful administration of the agents used, bearing in mind that these patients often have a low blood cell count and a low hemoglobin. Blood for transfusion should be readily available.

Problems in Cardiac Surgery

Edward E. Avery, M.D., Associate in Surgery, Northwestern University Medical School, Chicago—In heart and pulmonary surgery, fundamental problems are:

(1) Adequate oxygenation; (2) elimination of carbon dioxide which can build up in poor ventilation; (3) stabilization of mediastinum; (4) maintenance of adequate blood pressure, mainly to keep coronary arteries supplied; (5) balanced fluid replacement; (6) prevention of noxious reflexes and arrhythmias; (7) muscle relaxation, and (8) as little anesthesia as possible.

The main problem after the incision has been made is ventilation, not anesthesia.

The anesthetist should follow the patient back to his room and take care of postoperative complications which may have been the result of anesthesia.

New Anesthetists' Officers Named

Minnie V. Haas, R.N., chief nurse anesthetist, Harris Hospital, Fort Worth, Tex., has succeeded Mrs. Josephine B. Bunch, R.N., chief nurse anesthetist, Shriners' Hospital for Crippled Children, Portland, Ore., as president of the American Association of Nurse Anesthetists.

Other officers are: Lillian G. Baird, R.N., director, school of anesthesia, University Hospital, Ann Arbor, Mich., first vice-president; Olive L. Berger, R.N., director, school of anesthesia, Johns Hopkins Hospital, Baltimore, second vice-president; Agnes Lange, R.N., staff nurse anesthetist, Ravenswood Hospital, Chicago, treasurer (re-elected); and Florence A. McQuillen, R.N., Chicago, executive director (re-elected).

The organization's annual award of appreciation went to the hospital sisters of the Third Order of St. Francis, which operates St. John's Hospital, Springfield, Ill. Research showed that the hospital had the first school to train registered nurses in anesthesia. Sister Rudolpha, R.N., director, school of anesthesia, accepted the award.

A. O. R. N.

Questions and answers from the most

MODERATOR: Margaret C. Giffin, R.N., New York City, Assistant Director, Department of Hospital Nursing, National League for Nursing.

Participants:

SURGEON: Elliott Hurwitt, M.D., Chief of the Surgical Division, Montefiore Hospital, New York City

ANESTHESIOLOGIST: Vincent Collins, M.D., Director, Department of Anesthesiology, St. Vincent's Hospital, New York City

DIRECTOR OF NURSES: Edith Roberts, R.N., Director of Nursing, Methodist Hospital, Brooklyn

OPERATING ROOM SUPERVISOR: Marie Condon, R.N., Operating Room Supervisor, Jersey City Medical Center

OPERATING ROOM CONSULTANT: Frances Ginsberg, R.N., Consultant in Operating Room Nursing, Bingham Associates Program, Boston, and Assistant Clinical Professor of Nursing, Boston University School of Nursing

BACTERIOLOGIST: Earle H. Spaulding, Ph.D., Professor of Microbiology, Temple University School of Medicine, Philadelphia

ADMINISTRATOR: Mother M. Alice, O.S.S., St. Clare's Hospital, New York City

STERILIZATION AUTHORITY: John Perkins, Research Director, American Sterilizer Co., Erie, Pa.

CARL W. WALTER, M.D. (speaking from audience): I think what we need to solve this problem are facts. The facts concern the anatomic and bacteriologic condition of the skin of the individual when he enters the scrub room. If the person involved has been careful about his daily care; if he uses G-11 throughout the day; if he avoids contamination with dangerous organisms; if he does not have a respiratory infection; if he avoids changing tires; contaminating the skin in the workshop; fixing the kid's model railroad; playing with a dog, and monkeying around with the garbage—he's perfectly safe, each time he comes to the operating room, to brush his skin with nine strokes of a nylon bristle brush with a detergent containing G-11, and go into the operating room—bacteriologically as safe as anyone can make him.

On the other hand, this is rather an esthetic type of life which very few surgeons can live. Therefore, we find that most of them had better take a more active course; scrub their hands for 90 seconds and then go through a germicide that is known to be active on the dirt which very few of us eradicate thoroughly during a scrub. This means that they have to have a germicide which is a detergent as well to help penetrate this dirt.

Then we have the surgeon who scrubs only every 10 days. The bacterial flora on his skin have had an opportunity to completely re-establish themselves. He has to scrub 30 strokes to all areas of the skin with 50 strokes to the nail, and may spend 15 minutes getting down to the place of the person who scrubs daily, insofar as safe, clean skin and bacterial count are concerned. This man is more dangerous than the surgeon who

Problem Clinic

popular session at the First National A.O.R.N. Conference, New York City

Conclusion

comes in every day; this man is more dangerous than the nurse who comes in every day and spends 25 seconds, as Dr. Hurwitt described, getting into a case and not being late. So I think we have to abandon time as a factor in scrubbing; we have to abandon all these concepts of the past and rely upon good detergency, active germicide, and a keen analysis of the facts pertaining to the individual skin at the time the remedy is applied.

I'd like to make just one more comment on a previous question on how to get the staff to cooperate with these technics. I think you have to take a lesson from the Presbyterian Hospital here in New York. Someone there in the early 30's was confronted with this problem. He did postoperative studies, he gathered numbers. How many patients got infected? Technic talks for itself when you have to add up infections every month, month by month. Then the staff will gradually see whose cases are infected; what good results are; what bad results are. No pedagogic exercise such as you describe does any good unless it has some compulsion and some facts with it to make people think and add up end results, and not just get emotional satisfaction from prying into a single case — usually a successful one.

Q. Doesn't there have to be, administratively speaking, a standard, because it is so difficult to judge what has been the previous contamination of a person coming into the operating room?

DR. HURWITT: This is really a basic question that I have jotted down here to bring up at the end, but I think this is a good time to take it up. Dr. Walter's work on this subject is internationally accepted as outstandingly good, and there's no question about its validity. But he is in a high-powered atmosphere—back at the hub of the universe—and I do think that we have to gear ourselves perhaps to the pace of a Ford rather than a Cadillac, because we're not all in the Cadillac class. This comes right down to a standard, simplest technic, and Miss Roberts and others of you who are in the administrative aspect of nursing have stressed this again and again—the need for simplicity in organization.

I don't intend this as a dig at Dr. Walter or Dr. Brigham or anyone else, because I would like to be able to adopt this as a standard, but I know that in our hospital we would not be clean in 90 seconds.

I do agree completely that there should be a standard scrub. If detergents are used—and I guess there are few hospitals today that don't use detergents—then let us set three minutes, which I think nobody will say will damage your hands and everybody will agree will clean up all your bugs. Let's set this or something like this as a standard and make everybody conform to it — the person who scrubbed the day before as well as the person who scrubbed the week before, and the person who played with the dog and took care of the child or baby's diapers before he came to work — with the exception of the nurse or doctor who has gone from one case to another, who's really very clean and can take a shorter scrub.

DR. COLLINS: I believe that in carrying out operating room procedures, personnel should not be allowed to be guided by their consciences. Certain standard operating procedures must be set up. In the Army we saw just soap, water, and a brush used for 10 minutes by the clock. It was perfectly adequate, and few or no infections resulted out in the field.

MISS ROBERTS: I think the nursing service administrator might be very helpful here, in seeing that standard operating room procedures are, or can be, maintained.

I do not think the operating room supervisor should be given the burden of trying to discipline a surgeon. I think she has the responsibility of calling his attention to the procedures maybe once or twice, and then referring the matter to the nursing service administration, who can then refer it to the surgeon's colleagues on the committee to maintain operating room discipline. It's much more effective to have his own colleagues intervene.

Q. To whom is the operating room supervisor directly responsible?

MISS CONDON: We are responsible to the graduate school of nursing and to the surgeon, and to the associate director of nurses, who helps solve many of our problems. She in turn brings out problems to the director of the school. There they are solved and acted upon as she sees fit, and they go to the medical director.

Q. For what things, to what person, is the operating room supervisor directly responsible?

MISS GINSBERG: It's a very real problem, and one that is causing increasing concern throughout the country. In some hospitals there has already been a change making the operating room supervisor directly responsible to the administrator. I am in no position to say whether this trend is good or not.

In the hospitals in which this has evolved, the hours of work and the interaction between personnel seem to have improved. However, the plan is still in its embryonic stage. I cannot say at this point that it is the answer. I feel that as nurses, working in a hospital situation, we belong under the jurisdiction of the director of nursing service.

In most instances of which I am aware, the reason for the shift of control from the nursing administrator to the hospital administrator has been the poor interaction between the operating room supervisor and the director of nursing service.

If that's the answer, perhaps the change is all right. I'm sufficiently malleable to say that if it is going to improve the quality of care and the stature of nursing —which I doubt—I'm all for it.

MISS ROBERTS: I think a trend which puts another side to the question is the trend for the nursing service administrator to be considered on the same level in the hospital organization with other assistant directors, not other department heads. This is particularly true in the larger hospitals, so that the well-prepared nursing service administrator has a closer liaison with hospital administration than she probably has had in the past.

(Continued on next page)

We are getting many more effectively prepared nursing service administrators, who, I am sure, will be more capable and helpful.

MOTHER M. ALICE: We have in our hospital an operating room committee composed of the directors of surgery, obstetrics and gynecology, and anesthesia, together with the operating room supervisor. This committee holds monthly meetings. When they have serious problems or when they are looking for new equipment, I am invited to be present. Every man is free to express his own opinion and make known his problems.

As you know, there are many changes in technic, apparatus, etc., but the attending surgeons confer with their chiefs, solving difficulties at these meetings.

Complaints regarding nursing personnel in the operating room are and should be referred to the operating room supervisor, who usually makes the necessary corrections or changes herself, or with the advice of the director of nursing or her assistant.

We have a very busy operating room, because we have many emergency operations and have a large ambulance service. Cooperation from all is necessary.

Our operating room nurses have always been more than cooperative, and each seems to work compatibly with the other. We have our problems, as do all operating rooms, but the atmosphere in the operating room has always been a good one, and this, I feel, is due to the personnel.

Q. Do you use such a committee, Miss Condon?

MISS CONDON: We are planning now to form a committee in our school of nursing, and we feel that it will help solve some of the problems that arise in the operating room.

DR. COLLINS: I think this ties into the previous question. I believe the operating room supervisor should be a department head. I think she has two types of responsibilities—administrative responsibilities and functional, practical responsibilities. I believe she should be a full-fledged, voting member of an operating room committee.

In many places we've rather lost sight of the fact that hospitals exist as workshops for doctors to treat patients, and that eventually all the decisions of "how best to treat the patient" must, of course, come into line with medical thinking. Therefore, in essence, the operating room supervisor or department head, as a member of the operating room committee, actually has an opportunity to be kept posted on new developments in various surgical specialties.

The operating room committee, as Mother Alice noted, should be made up of at least six different people: the directors of the surgical specialties, the director of anesthesia, and the hospital administrator. Unquestionably the director, or departmental head of the operating room nurses must be a member of that committee.

I said the operating room supervisor has administrative and functional responsibilities. Now from the administrative standpoint there could be, and in our hospital there is, a joint administrative-executive conference held once a month, at which the directors of the various nursing services meet with directors of the medical services and present their administrative problems, such as pay, job satisfaction, security, and everything relating to responsibility.

Incidentally, I'd like to make a very important point to emphasize to hospital administrators and others in your various bailiwicks: If you are to assume responsibility, then you should be given authority with it. If you don't have authority to act, there's no sense in having responsibility. It is frustrating.

Q. In institutions in which the operating room supervisor is responsible to the hospital administration, who is responsible for staffing the operating room? Does the operating room supervisor directly hire and fire?

MISS GINSBERG: Yes.

Q. Couldn't that still be done in the more common pattern we have now, if there is adequate communication between the supervisor and the director of nursing services?

MISS GINSBERG: Regarding the development of this committee, for fear that we would continue our role as isolationists, seeing our department as a complete entity outside of the hospital, I've worked to invite, as participating active members of this committee, representatives of all departments that have to do with surgical aseptic technic. The delivery room and central supply supervisors are invited as members. Certainly their technic and procedures should be the same as those in the operating room; the central supply supervisor has problems of very real concern to operating room personnel. Everybody has to get together and discuss mutual interests. It does no good, I believe, to straighten out an operating room situation when the central supply is in a mess. And the same is true of the delivery room.

Until we reach a point where we can sit down and talk intelligently, with much light and no heat, to discuss all our problems and put them all on the table and look at them realistically, I don't think we're going to be very successful.

Q. Mr. Perkins, I understand nylon urethral catheters can be autoclaved. What temperature and time would you suggest?

MR. PERKINS: For urethral catheters of nylon, woven base or Latex types, I would recommend a temperature of 250° F. saturated steam for 30 minutes, with the consideration, of course, that they were properly cleaned beforehand. The lumen of the catheter should be moistened before placing it in the sterilizer.

Q. When no other type of sterilizer is available, how long should Vaselinized gauze be autoclaved at 250° F. to be safe for use?

MR. PERKINS: In the event that you have no hot air sterilizer available, there is general agreement that sterilization can be accomplished in the autoclave with steam admitted to the jacket only, maintained at 15-17 pounds pressure or 250°-254° F., and an exposure period of six hours or overnight. The sterilizing time varies with the amount of Vaseline gauze being sterilized at one time. Care must be taken to be sure that water is added to the Vaseline.

Generally speaking, I do not recommend the use of the autoclave as a substitute for the hot-air sterilizer, although I realize that many of the hot-air sterilizers being sold today are lacking in efficiency. From experience I have observed that when the autoclave is used as a substitute for the dry-heat oven for sterilization of Vaseline-impregnated gauze, oils, etc., some spillage frequently occurs, the chamber becomes contaminated with a film of oil, and the air discharge line becomes partially clogged, thus imposing a service problem upon the hospital. I do feel that it is the responsibility of manufacturers to design suitable equipment for dry-heat sterilization. Autoclaves are not made to perform this service efficiently.

Q. How long do you advocate autoclaving cotton and silk sutures?

MR. PERKINS: For 30 minutes at 250° F. saturated steam.

Q. For what length of time are sterile goods considered sterile?

MR. PERKINS: The evidence at hand indicates that sterile supplies placed in clean storage can be considered to remain sterile for at least three weeks. We have been conducting a study during the past two years with one of the local hospitals in Erie (Pa.), in an effort to evaluate the length of time that syringes, for example, wrapped in double-thickness muslin, instead of paper bags, would remain sterile in supposedly clean storage within the central supply department. So far as we have been able to determine, the evidence indicates that either method of packaging will preserve sterility for at *least* three weeks.

Beyond that time, I don't know how we're going to evaluate sterility, because during long periods of storage both the muslin-wrapped packages and the paper bags become so heavily covered with dust particles which constitute a source of contamination of the cultures, that when the package is opened it is very difficult to determine whether contamination actually gained access to the interior of the package during storage.

Q. Since instruments must be opened before being sterilized in the pressure instrument washer-sterilizer, what is the best method for laying the instruments in the tray or basket to facilitate simple removal?

MR. PERKINS: It is always desirable to place the instruments in the tray with some semblance of order. We have been working on the development of a U-shaped pin on which you can hang or place the jointed instruments, making sure that they are fully opened for effective sterilizing but assembled in an orderly manner. However, various sizes of U-shaped pins are indicated because of the various sizes of hemostats, and this feature is somewhat troublesome. I feel that it is essential that all jointed instruments be unlocked when placed in the sterilizer in order to effectively expose the box locks or joints, which frequently contain dried blood. This method will assure proper sterilization of the instruments.

Q. Dr. Collins, what should be the relationship between anesthesiologist and operating room supervisor in regard to the care and cleaning of anesthesia equipment?

DR. COLLINS: Whenever possible, I believe there should be an anesthetic nurse and a trained technician to care for anesthesia packs, like spinal, and the nerve block sets. I do recognize that if you have the facilities and a very excellent, large central supply it could come under that department. I personally prefer to have an anesthetic nurse as well as a technician taking care of my needles, and being trained specifically to sharpen them.

Q. Would this anesthetic nurse be responsible to you?

DR. COLLINS: Absolutely!

Q. And not to the operating room supervisor?

DR. COLLINS: No relation! This nurse is part and parcel of the department of anesthesia.

Q. What part does the nurse play in the administration of anesthesia and the care of the anesthesia machine? Now I take it that you're not talking about the trained nurse anesthetist.

DR. COLLINS: I definitely feel that there is a place for nurse anesthetists, and there will be for some time to come. I believe, however, they're coming under the jurisdiction in more and more instances of the anesthesiologist, and certainly many of the girls whom I've talked to feel more secure when they can present their problems to the medical anesthesiologist.

As far as the care of the anesthesia machine is concerned, it doesn't make any difference whether a nurse uses it or a doctor uses it—I feel that it's *his obligation* to take care of the machine. I think perhaps the technician engaged in the department can adjust it once a day or once a week or whenever it's necessary, but the immediate, first-echelon care is the responsibility of

(Continued on next page)

Pennsylvania Operating Room Nurses Elect Officers

Officers of the Pennsylvania Operating Room Nurses Association for 1954-55 are, seated (l. to r.): Edith Johnson, Graduate Hospital, Philadelphia, first vice-president; Pauline R. Young, Hahnemann Hospital, Philadelphia, president; and Regina Vonderweight, Abington Hospital, Abington, secretary. Elizabeth Marcin, Temple University Hospital, Philadelphia, treasurer, is standing.

the man that uses it. And that means replacing the tanks, making sure the valves work, and all of that. Unless the anesthetist trains a technician to the point where he is a real genius, I feel that the responsibility should not be entrusted to that person.

MISS GIFFIN: We have one more very difficult one that you can answer, I'm sure, Dr. Collins: If cyclopropane is used relatively often by the anesthesia department, which does not insist on conductive shoes on all personnel, or does not believe that they are necessary, what should the operating room supervisor do about it?

DR. COLLINS: You've isolated in the question one anesthetic agent, and that of course is erroneous, because five others are equally as hazardous.

Let us not be complacent about the idea held by many hospital and medical people that if ether is being used, there's no need to think of explosive hazards. In the only two situations in which I personally have been associated—one a fire, and the other an explosion—ether was the agent being used! In the explosion case, the patient died.

The newspapers are very eager to headline operating room explosions. It seems that whenever cyclopropane is involved it makes headlines, but when ether is involved you never hear about it. Yet here in Manhattan two years ago there were three explosions with ether, and only two with cyclopropane. The latter made the newspapers; the others didn't.

Regardless of the anesthetic agents, the proper footgear must be worn.

If it's a matter of flooring, there's a grandfather clause, as you know, in the national fire protection code. It's a simple thing, almost a legal entity. They don't expect you to go change your operating floors tomorrow. But they do expect you at some time in the next 25 years when a floor needs replacing to consider the proper type of conductive flooring. In the meantime there are some precautions to be taken. You can scrub your floors with a solution that contains calcium chloride 4 percent that will make them partially conductive and eliminate partially your electrostatic hazard. And I feel very strongly about personnel wearing only cotton outer clothing, and of course the proper conductive shoes. The anesthetist who feels that conductive footgear is not necessary I consider a mere renegade technician — not a physician or an anesthesiologist.

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MISS HALL: Dr. Hurwitt, will you make a few closing remarks?

DR. HURWITT: This has been a happy meeting, and a most stimulating experience for all of us on the panel. We all profited in no small measure; we have highlighted some of the things in our own institutions that we were taking for granted, and we have brought out

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I have always felt that this is probably due chiefly to improper use of the instruments rather than to the method of sterilization. This has been your own feeling, I believe, as expressed in your book.

Recently, a new operating room superintendent has reintroduced cold solution sterilization for scissors, using a three hour period in Bard-Parker solution. This has caused me concern, chiefly because it seems to me unnecessary; and also because we have a constant turnover in personnel, and the difficulty in controlling the human element seems insurmountable.

Furthermore, I am apprehensive about the contamination of the instruments with formaldehyde. Is the

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HOSPITAL TOPICS

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I find that I cannot eliminate moisture from these tubes after sterilization has been completed, and I do not feel safe in storing these needles. I process the needles, and all other materials, in accordance with the directions given in the manufacturer's instruction book. I have tried variations of these methods, but without consistent success. Can you offer any suggestions?

A. Constrictor tubes such as you mention are difficult to process so that they can be removed from the steam sterilizer absolutely dry. The moisture in the tube indicates that they have been sterilized properly but the steam does not escape at the end of the sterilizing process, and condensation occurs.

I suggest that they be dried by exposure to dry heat to drive off the moisture. Placing them on top of the sterilizer while the next load is being processed should do the trick. Also, preheating the glass tubes to avoid excess condensation during sterilization is effective.

Q. All literature published regarding the sterilizing of oil and Vaseline states that this procedure should be carried out in the hot air sterilizer or by oven heat.

Would you give us your opinion on the validity of the material published?

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Furthermore, I am apprehensive about the contamination of the instruments with formaldehyde. Is the evidence that autoclaving does not damage scissors sufficiently conclusive that I can take a positive stand on this?

A. Steam sterilization does not affect properly made stainless steel scissors and is the only reliable way of controlling the transmission of the virus of homologous serum jaundice, other than prolonged dry heat sterilization. I have been increasingly uncomfortable concerning the use of cold sterilization of any kind.

I would recommend that you use dry heat sterilization as the safest, most innocuous method and one suitable for all types of cutting edge instruments. A sterilizer such as illustrated in Figures 112 and 94-4 of *Aseptic Treatment of Wounds* is satisfactory.

Failing this, instruments can be sterilized by dry heat simply by loading them into the steam sterilizer, turning the steam into the jacket but not the chamber, and leaving them there all night. In this way, they are exposed for at least four hours to a temperature of 121° C.

Q. I use a small autoclave for all autoclaving in the doctor's office in which I work and I find I have one troublesome problem.

We use B.D. constrictor tubes for needle containers. I find that I cannot eliminate moisture from these tubes after sterilization has been completed, and I do not feel safe in storing these needles. I process the needles, and all other materials, in accordance with the directions given in the manufacturer's instruction book. I have tried variations of these methods, but without consistent success. Can you offer any suggestions?

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Another problem in the sterilization of anhydrous materials is heating the material. Energy is transferred in the dry heat process by convection, radiation and conduction. The role each mode plays depends upon the type of sterilizer used. Hot air ovens utilize convection, often forced. Dry heat sterilizers have electrically heated shelves where conduction and radiation are the important factors. Steam sterilizers, with 250° F. in the jacket, heat by radiation and convection.

The material itself must be heated throughout. This occurs by conduction and is a relatively slow process because the quantity of energy available is low. It takes 60 minutes for 30 cc. of petrolatum in an ointment jar to reach 160° C. when in contact with an aluminum plate heated to 160° C. In hot air this same jar requires 110 minutes exposure. Sterilization by dry heat is therefore time-consuming.

Fires occur when the materials are heated above their flash or ignition points. This happens because the temperature control of hot air ovens is faulty and overheating occurs.

Petroleum jelly is logically sterilized in a dressing sterilizer. Thirty minutes exposure to saturated steam at 121° C. serves to heat and hydrate even large masses. The steam is then vented from the chamber and the radiant energy from the jacket sterilizes the jelly by dry heat at 121° C. during a four hour exposure.

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(*Continued on next page*)

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B. subtilis is a resistant type, nonpathogenic, spore former and cultures of this organism when properly prepared are the best available for periodic checking of your autoclave for efficiency.

Best authority, however, indicates that an autoclave will destroy this culture in *one-third the time required to melt a Diack Control.*

Then the safety factor you have in every day use of Diack Controls is at least three times the killing time required for B. subtilis. This explains why routine use of *properly placed* Diack Controls will protect the hospital operating staff from any chance of using dressings which have not been definitely sterilized.

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A.O.R.N. PROBLEM CLINIC

(Continued from page 76)

problems that we weren't aware of, problems that could stand real improvement.

I always get a tremendous thrill out of talking before a group of nurses. This is by far the largest group of nurses that I've ever been confronted with.

I think it's a privilege to work in an operating room. This is without any sentimentality or anything else. The operating room is the most exciting, the most dynamic, the most imperative area in the hospital. I think perhaps at times we lose sight of the fact that under most circumstances the problems of the operating room are not so stupendous that one has to have a lawyer, a hospital administrator, and an entire formal organization to work them out. For the most part they can be worked out by a compatible operating room supervisor and the person designated by the hospital administration to represent the professional services of the hospital.

I *do* believe that there are situations in which the operating room committee is very important, but I think these situations are in the minority. In a hospital that is moving along smoothly, where you have this kind of compatibility between the administrative head of the nursing services in the operating room, and the administrative head of the professional services, I think that almost all our problems can be worked out on this level.

Some remarks have been made about supercilious surgeons, or surgeons who have very pompous, didactic attitudes. I'd like to go back for a second to my not too remote past, when I put on my first uniform at the Massachusetts General Hospital and was quite overwhelmed by operating room nurses who thought, "Aha, another new doctor. Pretty green. Doesn't know very much." You girls also have to give a little bit as well as expecting the doctors to give a little bit, when you're in an institution in which the interns are on a rotating basis, coming through the operating room in new batches every six weeks or every two months.

Some of these boys are interested in psychiatry or dermatology, or other areas. They're not going to know a great deal about surgery. They're not going to be antagonistic until they're antagonized by a group of super-O.R. people who know a great deal more than these boys would or should. But if you'll be big sisters to them and just show them instead of barking at them, I think you'll get along better with the doctors, and the doctors will get along better with you.

I was very grateful for Mother Alice's compassion for us nervous surgeons. It's a great help to have a mature, motherly influence in the operating room. There are times when we do get a little bit upset, sometimes when the blood starts to spurt a little bit more freely than we would like. A calm, assured operating room nurse, again one whose face, not back, is toward you, is a tremendous source of comfort to the surgeon, and often may help save the patient's life.

I've been very much impressed by the practical nature of the questions to the panel. You're very much interested in the immediate technological aspect of your work. What impressed me even more was the sociologic aspect of operating room nursing, which frankly had never occurred to me before. I'm delighted that you are more concerned with what's happening to the patient than with who's going to relieve you at 4 o'clock so you can get unscrubbed and get to do what you had scheduled for 4:30.

Almost every question raised, stirred a controversy here on the panel—which shows that nothing is all white or all black. The fact that those of us selected to discuss some of these problems are not unanimous in our appraisal of them should not be disturbing to you, but should really re-emphasize the short distance that we've gone. There is a great amount of distance that has to be covered before we can really be complacent, and I doubt if we ever will be complacent about the operating room.

I never dreamed that your first national organizational meeting would have such a tremendous registration; would have such sincere interest. It's awfully gratifying to those of us who are doing the operating room work to know that our counterparts are so deeply interested.

QUESTION BOX

(Continued from preceding page)

Q. We sterilize our syringes and needles in a steam autoclave. Is it necessary to rinse them in ether, after washing with detergent and rinsing in distilled water, before autoclaving?

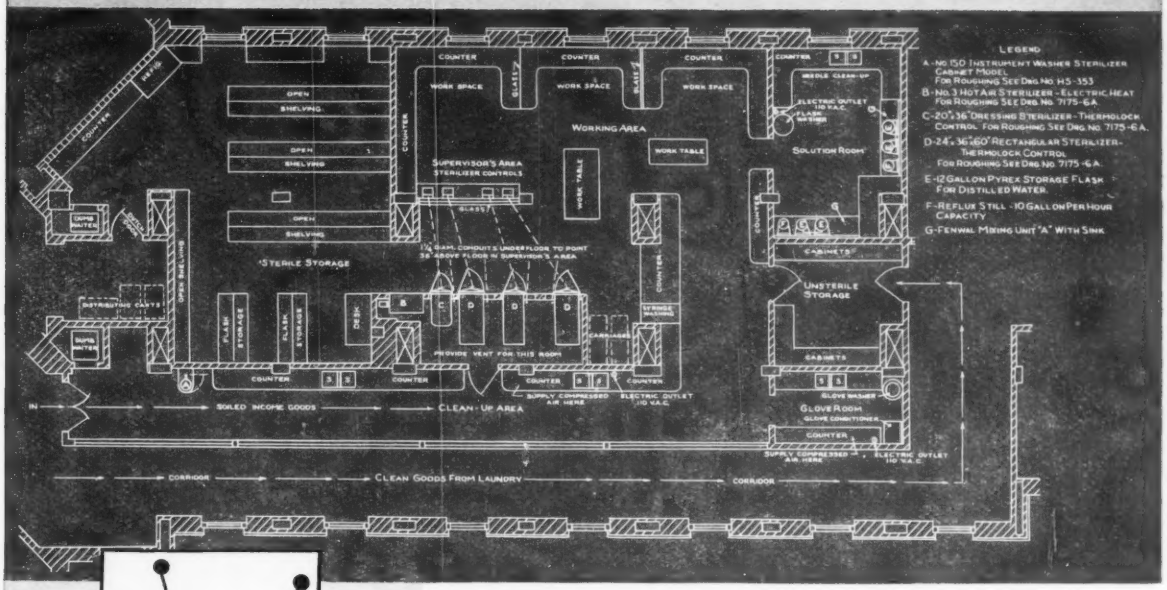
We keep our parenteral solutions in a place where the temperature drops to below zero. Is this dangerous?

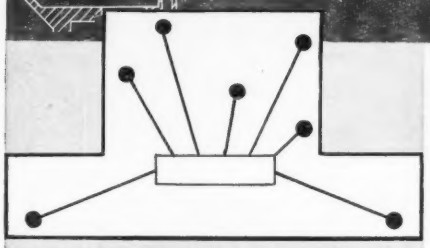
A. Ether contributes nothing to the care of syringes.

Syringes should be washed in a hot detergent solution, rinsed well, and sterilized in saturated steam at 250° F. for 30 minutes.

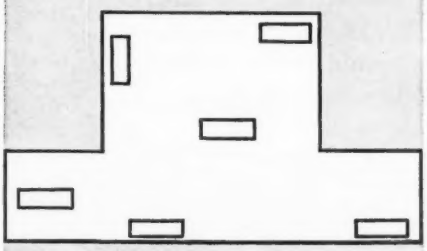
The only danger in exposing the parenteral solutions to sub-zero weather is that of the glass bottle breaking.

A CENTRAL STERILE SUPPLY CUTS COSTS





Typical Central Sterile Supply centralizes facility for greatest economy.



Decentralized system means increased equipment and personnel expense.

SAVES IN EQUIPMENT — PERSONNEL — TIME

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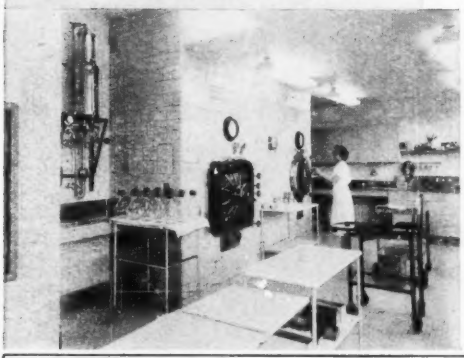

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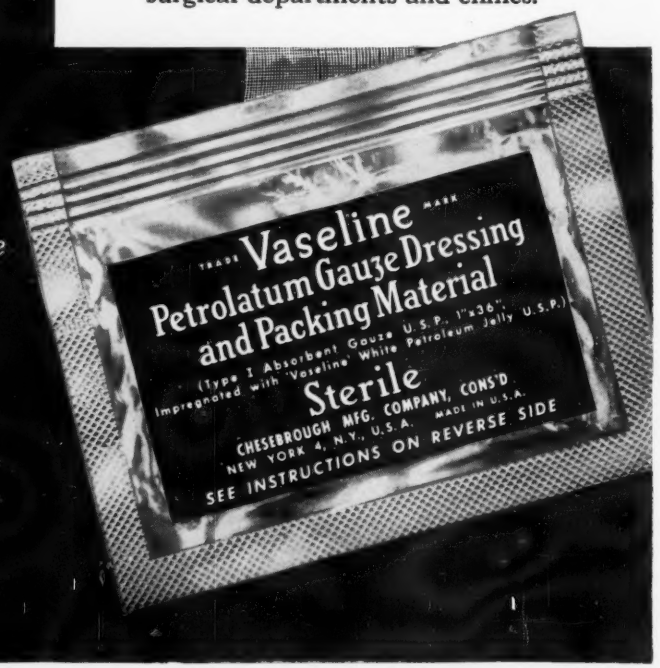
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This Pharmacy Department Operates a Central Sterile Supply

● Under whose control should the central supply department be? At the 500-bed Clinical Center of the National Institutes of Health, Bethesda, Md., central sterile supply is a section of the pharmacy department, which is headed by Milton W. Skolaut. Smooth functioning under this arrangement is facilitated by having the central sterile supply department centrally located and in the basement, directly under the pharmacy, so that Mr. Skolaut and Joseph N. Salvino, chief, central sterile supply, can work very closely together.

Research sterile solutions are made in the pharmacy in a special area, but are dispensed from central sterile supply. Solutions made routinely are irrigation solutions such as normal saline. Also manufactured there are nupercaine and triple sulfa, experimental IV solutions, ACD solution, and any solutions the department is called upon to make for use in research projects conducted at the institutes. Otherwise, solutions are purchased, except for those that cannot be obtained commercially.

The spacious central sterile supply section was operating at far under capacity when HOSPITAL TOPICS visited there, because the center had reached only slightly under a third of its maximum patient load. To give an example of the department's volume, however, during a recent month in which there were 150 patients in the center, 26,000 items were dispensed from central sterile supply—an average of 7.7 items per patient per day.

Additional pictures on next two pages

Photo at top of page shows staff at work in assembly area. Employee in foreground is marking trays with mechanical marker. Tape shows date and autoclave load number, and indicates a coded recall date. Information is filed on record card for ready reference. Below: Mr. Salvino in glassed-in office which affords good view of all parts of the department.

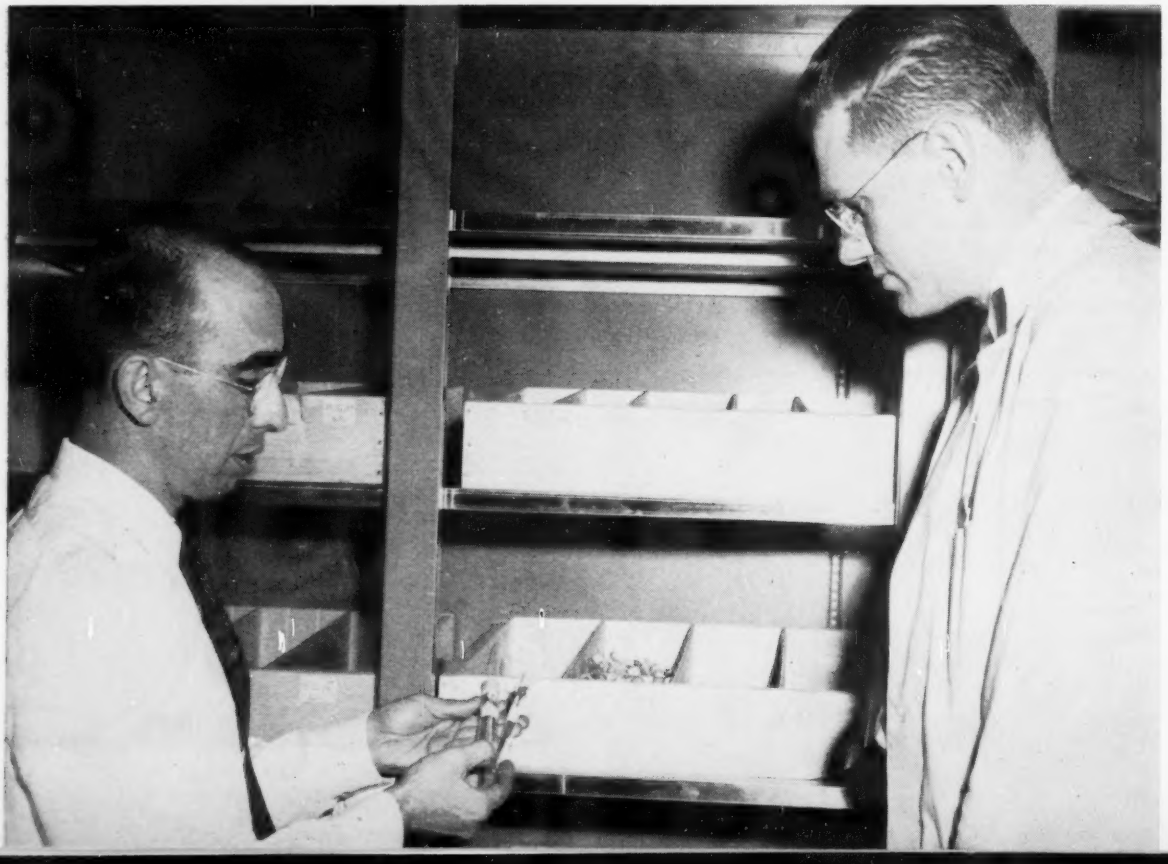
Name and contents of trays are listed on label on outside of tray. Mr. Salvino and Mr. Skolaut show label on clean throat irrigation tray. Ninety-four trays are routinely available from department. Pictures showing set-ups will be placed on Kardex cards.

Above: Gussie Gaskins puts syringes in rack before washing. They are washed in detergent, rinsed twice with tap water, and then with distilled water. After they come out of the needle cleaner, they are dried, assembled, tipped (with plastic tips), and sterilized.

Above left: Evelyn Gaskins wraps 4 x 4's in paper wrapper. Stapling machine is in background. The department uses packages of six. Mr. Skolaut thinks canisters are going out of date.

Left: To try to avoid or reduce resharpening of needles, the department asked units to replace them in a sponge, as Lloyd Taylor does here. Twenty-one different needles are available in department.

Below: After needles are removed from the sterilizer, Scotch autoclave tape is placed over the cotton at the tip, to keep the cotton from being pulled out accidentally. Mr. Salvino (l.) shows Mr. Skolaut tip which has been covered with tape.



Above: "Loan area," showing variety of large equipment stored in central supply.

Below: Annie Robinson is shown at glove tester in glove room. Gloves were being washed by hand, but will be done in the laundry.

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DEATHS

(Continued from page 67)

John Shepard Parke—58, executive vice-president, The Presbyterian Hospital, Columbia-Presbyterian Medical Center, New York City, died in August.

Mrs. Lillian B. Patterson—53, dean, University of Washington School of Nursing, died Sept. 8. Mrs. Patterson was a past president of the Washington State Nurses' Association, and a member of the board of directors and a former officer of the American Nurses' Association.

F. J. Slataper, M.D. — 73, former chief pathologist for the city of Houston, died Sept. 18.

Maud Slye, M.D.—75, former associate professor of pathology, University of Chicago, died Sept. 17. Dr. Slye was noted for her extensive cancer research on mice, concentrating on the hereditary aspects of the disease.

Wilbur Ward, M.D. — 75, former professor of obstetrics and gynecology, New York (N. Y.) Polyclinic Medical School and Hospital, and a past president of the New York Obstetrical Society, died Sept. 20 in Pasadena, Calif.

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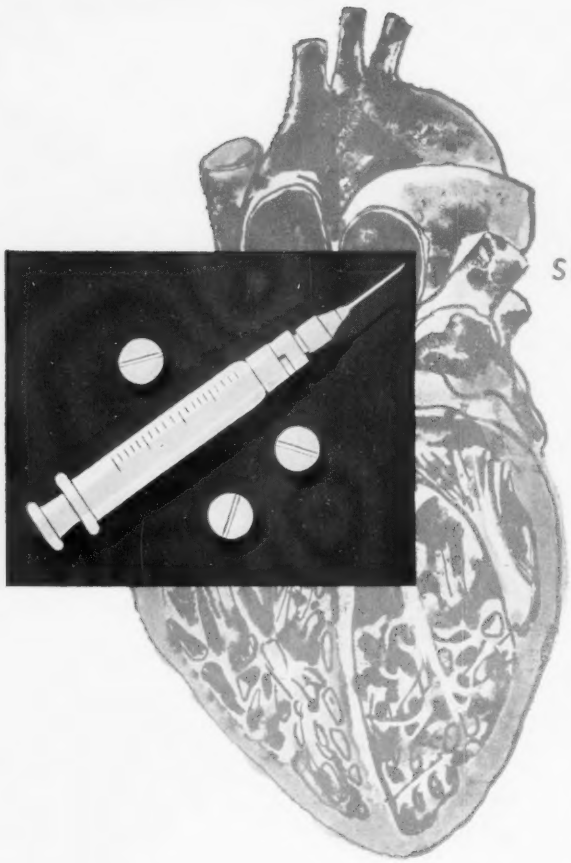

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